Multi Culti Med

MODERN MULTICULTURAL EDUCATION

FOR MEDICAL AND HEALTH SCIENCE STUDENTS

Academic Editor:
Małgorzata Szkup

Prepared within
Erasmus+ KA220 project
MultiCultiMed

Co-funded by
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Authors

Małgorzata Szkup, Małgorzata Zimny, Magdalena Stankiewicz, Magdalena Kuczyńska, Karmen Erjavec, Sabina Krsnik, Maria A. Marchwacka, Emilia Burbela, Olha Fedortsiv, Volodymyr Dzhyvak, Elena Rousou, Panagiota Ellina, Paraskevi Charitou, Marzena Mikła, Paloma Moral de Calatrava

Expert review

Prof. Dr. Meryam Schouler-Ocak, Dr Irena Papadopoulos

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Wydawnictwo Pomorskiego Uniwersytetu Medycznego w Szczecinie

ul. Rybacka 1, 70-204 Szczecin

www.pum.edu.pl/uczelnia/wydawnictwo

e-mail: wydawnictwo@pum.edu.pl

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Foreword

Modern healthcare operates at the crossroads of dynamic social, cultural, and demographic transformations. In an era of globalization, mass migration, aging populations, and the growing importance of human rights and equity, medical education can no longer be limited to the transfer of clinical knowledge alone. It is essential to prepare future healthcare professionals to act effectively, empathetically, and equitably in increasingly culturally diverse professional environments.

This handbook was created precisely in response to these challenges. It is the result of a unique collaboration among an international team of experts and combines the latest approaches in intercultural education, academic knowledge, and practical experience. At its foundation lies the original EMPOWER model — a conceptual and educational framework that promotes effectiveness, multiculturalism, professionalism, occupational well-being, and access to supportive educational resources. This model supports the development of reflective cultural competences and encourages treating patients as equal partners in the therapeutic process.

This book is not just a source of academic knowledge — it is an invitation to dialogue, reflection, and change. It offers the reader a space to consider cultural humility, selfawareness, and shared responsibility in building a healthcare system that is open to diversity. It also serves as a theoretical cornerstone of a broader educational ecosystem, enriched by practical tools and interactive exercises available through the MultiCultiMed platform.

I encourage you to approach this publication in a personal and engaged way — as a student, a future professional, and as a human being.

With kind regards,
Małgorzata Szkup

About the MultiCultiMed Project

This handbook was developed as part of the MultiCultiMed – modern multicultural education for medical and health science students project (Project No. 2024-1-PL01-KA220-HED-000251323). It is an international initiative carried out by six universities from Poland, Spain, Slovenia, Cyprus, Ukraine, and Germany. The project was launched in response to the growing demand for culturally competent healthcare professionals and the need to modernize educational systems across Europe.

MultiCultiMed addresses key global challenges — migration, aging populations, and health inequalities — through an innovative and integrated approach to multicultural education. It equips students not only with theoretical knowledge but also with practical tools to foster empathy, understand diversity, and work effectively in multicultural teams.

The main outcomes of the project include:

- a multilingual, academically grounded handbook,
- an interactive educational platform with exercises aligned with the textbook content,
- a methodological guide for teachers and mentors,
- and the Human Library — a collection of real-life stories from individuals representing marginalized or culturally diverse groups.

Together, these components form a flexible, multidimensional educational system that supports the development of cultural awareness and professional competence among students of medicine, nursing, psychology, dietetics, physiotherapy, and other health sciences.

We warmly invite you to explore this material and join our collective effort to shape a more inclusive, equitable, and human-centered future for healthcare — in Europe and beyond.

The MultiCultiMed Team

Multi Culti Med

Chapter 1

The EMPOWEeR Model

– An Innovative Framework for Multicultural Education for Students of Medicine and Health Sciences

MAŁGORZATA SZKUP
Pomorski Uniwersytet Medyczny w Szczecinie (Polska)

> **An education that teaches you to understand the world, its people, and their diverse perspectives is the greatest tool for promoting peace, empathy, and cooperation.**
>
> — Kofi Annan

1.1. Introduction

Modern multicultural education for medical and health science students is an educational approach that integrates principles of **cultural diversity, equity,** and **inclusivity** into medical training. It is increasingly recognized as a crucial component in the education of health professionals, providing the opportunity to develop skills, which are sensitive to culture and discrimination for effectively working with diverse patient populations. As societies become more multicultural, medical education has shifted towards a curriculum that emphasizes **cultural competence**, enabling future healthcare providers to understand and address the varying health needs influenced by cultural backgrounds (Liu, et al., 2022; Verbree, et al., 2023; Papadopoulos, 2024). The notable rise in the significance of multicultural education in medical curricula stems from an awareness of the significant disparities in health outcomes among different divers cultural groups. Research indicates that culturally competent care not only improves patient satisfaction but also enhances healthcare delivery by addressing the unique challenges faced by minority communities (Majda, et al., 2021). Consequently, medical universities are revising their educational strategies to include cultural competency training as one of the goals of education (Liu, et al., 2022; Zanetti, et al., 2014). Despite the positive developments, the implementation of multicultural education is not without challenges. Critics highlight issues such as inadequate institutional support, persistent stereotypes, and the need to implement more effective methods of education and assessment of cultural competencies (Srinivasan, et al., 2024). This is an ongoing process, which needs monitoring for the evaluation and adaptation.

Central to the EMPOWER model are:
- *empowering students in multicultural education*
- *promoting patient empowerment.*

The discourse surrounding these challenges underscores the importance of ongoing efforts to refine educational practices and foster an inclusive environment that prioritizes **cultural humility** and **awareness** in healthcare training. The transformation of healthcare education, incorporating these elements, is crucial for training a workforce capable of navigating the complexities of an increasingly interconnected world. Equipping future healthcare professionals with the necessary skills, knowledge, and shaping their attitudes toward working with diverse communities can play a vital role in promoting equity and improving health outcomes within the healthcare system (Verbree, et al., 2023; Majda, et al., 2021).

The **EMPOWER model** is an innovative, proprietary approach to multicultural education, specifically designed for medical and health science students, aimed at enhancing reflective cultural competencies and cultural humility among future healthcare professionals.

The **EMPOWER model** aims to enhance the effectiveness of multicultural education and tailor it to the real-world challenges of daily practice. It focuses on **strengthening the roles of both students, teachers, qualified health workforce and patients,** contributing to the co-creation of a more open and supportive environment for acquiring competencies. Empowering students emphasizes self-di-

rected learning and active engagement, equipping them with the skills necessary to function effectively in diverse clinical environments.

Strengthening the role of patients autonomy promotes self-management of their health and participation in medical decision-making capacity, enabling active involvement in healthcare. By integrating these elements, the EMPOWER model aims to foster attitudes of personal commitment, humility, reflection, responsibility, and openness. Implementing its principles into multicultural education will bridge the gap between theoretical knowledge and its practical application.

As a new concept in medical education, the EMPOWER model not only aims to improve the effectiveness of training future healthcare professionals but also addresses the urgent need to ensure equity and better health outcomes for patients, particularly those from marginalized groups. Its focus on deeply engaging educational experiences gives it the potential to become a valuable tool in creating a more inclusive healthcare system that meets the diverse needs of patients and communities.

Given the dynamic development of multicultural education and its vast scope, continuous critical evaluation and adaptation of the model to various educational contexts will be necessary.

Aims

Through this chapter students will enhance their attitudes, knowledge and skills in:

- Understanding the basic principles of multicultural education in medicine and health sciences,
- Comprehending the significance of reflective cultural competencies, cultural humility, professional well-being, educational resources, and tools supporting inclusivity in healthcare training,
- Familiarizing with the EMPOWER model as an innovative approach to multicultural education, aimed at strengthening both the role of students and patient-centered care,
- Enhancing the role of patients in improving health outcomes and promoting health equity,
- Engaging in self-reflection regarding personal biases and stereotypes, thereby supporting the development of cultural humility and awareness in medical practice.

Learning Outcomes

By the end of this chapter, readers will be able to:

- To explain the basic principles of multicultural education in the context of medicine and health sciences, emphasizing its importance in shaping a diverse and inclusive healthcare environment,
- To describe the concept of cultural humility and its significance in medical practice, highlighting its role in improving the relationship between patients and healthcare providers and in enhancing treatment outcomes,

- To utilize educational resources and tools supporting inclusivity in developing one's own reflective cultural competencies, striving to understand the phenomenon of diversity in healthcare settings,
- To analyze and apply the EMPOWER model in the context of multicultural education, demonstrating its impact on improving the educational and care processes by focusing on strengthening the roles of both patients and students,
- To understand the principles of strengthening the role of patients and explain its impact on improving health outcomes, decision-making capacity, and promoting greater health equity among diverse patient groups,
- To critically reflect on personal biases and stereotypes and apply the principle of cultural humility in medical practice, understanding how these biases influence clinical decision-making, patient care, and communication,
- To demonstrate the ability to create an inclusive and culturally sensitive healthcare environment, incorporating key elements of multicultural education and strengthening the role of patients in clinical practice and daily interactions with patients.

> *Every human being has the right to have their cultural and spiritual needs understood, just as much as their physical and psychological needs are expected to be met.*
>
> *Madeleine Leininger*

1.2. The EMPOWER Model – Key Components

In response to the growing need to adapt medical education to diverse societies, a new approach to multicultural education is proposed, based on the EMPOWER model, which aims to strengthen the competencies of students in medicine and health sciences. This model has 5 key characteristics that together describe a comprehensive educational framework supporting the development of future healthcare professionals in a multicultural context.

E – Effective – emphasizes the importance of efficiency in education, focusing on optimizing teaching and learning processes. Educational effectiveness means not only delivering knowledge but also equipping students with the ability to apply it in diverse clinical settings, which forms the foundation for high-quality healthcare.

M – Multicultural – highlights the significance of incorporating cultural diversity into educational programs. In the era of globalization, the ability to understand and respect different cultures is essential when working with patients from various backgrounds. Introducing the concept of multiculturalism into the curriculum enables students in health sciences to better prepare for engaging effectively with patients who have different values, beliefs, explanations, expectations, and health needs.

P – **Professional** – relates to a high level of human sensitivity, professional knowledge, experience, and ethical conduct. The education of medical and health science students is not only about learning technical skills but also about developing attitudes based on empathy, ethical behavior, and commitment to the well-being of patients. These values are the foundation of high-quality healthcare and contribute to building trust between patients and healthcare professionals.

W – **Wellness** – emphasizes the importance of ensuring the development of professionals in an environment that supports their health and well-being. Promoting wellness in medical education means creating a space where students not only learn how to care for others but also how to take care of themselves, both physically and emotionally. This approach is particularly important in the context of the increasing health challenges that healthcare professionals must face.

ER – **Education Resource** – focuses on providing appropriate educational resources that support the development of cultural and professional competencies among students. Appropriate educational materials, such as literature, digital tools, and engaging sets of practical exercises, are essential for students to develop their healthcare skills while considering social and cultural diversity.

Thus, the EMPOWER model represents an innovative approach that not only enables students in medicine and health sciences to develop in a cultural context but also prepares them for future work in an increasingly diverse society. By integrating these five key characteristics of the model – **effectiveness, multiculturalism, professionalism, wellness, and appropriate educational resources** – this model strengthens students' competencies, preparing them to be leaders in healthcare and advocates for health equity in a global context.

E – Effective - emphasizes efficiency
M – Multicultural - emphasizes multiculturalism
P - Professional - high level of humility, expertise, competence, and ethical behavior
W – Wellness - developing professionals in a health and wellness supportive environment
ER - Education Resource - appropriate educational resources

The attached model presents an approach grounded in humility as the central element supporting four key pillars of effective functioning in professional and educational settings. These pillars include:

- Reflective cultural competencies,
- Professional wellness,
- Education resources,
- Supportive tools.

This model emphasizes that **humility serves as the foundation** for the development of each of these areas, fostering a more conscious, responsive, and balanced work and learning environment (Fig. 1).

Fig. 1. Key elements of EMPOWER Model

1.3. Cultural Humility in the Cultural Education of Medical and Health Sciences Students

The concept of cultural humility emerged in the late 1990s. It was defined as a dynamic and lifelong process that emphasizes self-reflection and personal critique in order to recognize one's own biases and limitations. It recognizes that cultural identities are complex and continuously evolving, highlighting the importance of an ongoing curiosity rather than a finite mastery of cultural knowledge (Pawlak-Sobczak, 2019). In contrast to cultural competence, which may suggest the existence of a point at which learning about different cultures is complete (achieving competence), cultural humility promotes the understanding that learning is a never-ending journey, requiring individuals to remain open to new experiences and perspectives (Lekas, et al., 2020) (Tab. 1).

The roots of the concept of cultural humility are linked to efforts to improve healthcare interactions with diverse social groups. The introduction of cultural

Table 1. Comparing Cultural Competency and Cultural Humility

	Cultural competency	Cultural Humility
Objectives	To develop a deeper understanding of minority cultures (target groups) in order to offer services in a more effective and suitable manner.	To promote self-reflection and development regarding culture to enhance service providers' awareness.
Core principles	Knowledge Training	Self-reflection Co-learning

	Cultural competency	Cultural Humility
Limitations	Reinforces the notion that one can be ‚competent' in a culture different from their own. Perpetuates the myth that cultures are uniform. Relies on theoretical knowledge rather than lived experience and assumes that professionals can be „certified" in cultural understanding.	Difficult for professionals to fully understand the concept of learning alongside and from patients. Lacks a definitive outcome, which can be challenging for those in academic and medical fields.
Advantages	Enables individuals to work towards achieving a goal. Encourages the development of skills.	Promotes continuous learning without a fixed endpoint, focusing on the value of the process of growth and understanding. It supports the building of positive relationships between professionals and patients, aiming to reduce harmful inequalities in healthcare.

humility was partly inspired by the recognition of systemic inequalities faced by marginalized groups.

Although the cultural humility approach is gaining popularity, the authors emphasize that one should not be chosen at the expense of the other. Instead, they propose a "both/and" model, which integrates the strengths of both approaches. They argue that:

- Cultural competence and cultural humility are complementary,
- Together, they support a more effective and equitable practice in health and social care, especially in the face of growing diversity and social challenges (Greene-Moton & Minkler, 2019).

The iceberg model serves as a foundational metaphor in discussions about cultural awareness, highlighting that culture is not just about observable behaviors but also encompasses deeper layers, such as values and beliefs (So, et al., 2023), Fig. 2.

This model, along with others, emphasizes the complexity of cultural interactions, further reinforcing the need for **cultural humility as a complementary approach to cultural competence**, enriching purely theoretical knowledge with a reflective component. As cultural humility gained traction, it became recognized as essential for fostering meaningful partnerships between healthcare providers and communities, where power dynamics and historical contexts are acknowledged and addressed. This shift towards a more inclusive and reflective practice aligns with broader trends in medical and health education, where the focus is increasingly on developing professionals who are not only knowledgeable, but also empathetic and responsible in interactions with patients from diverse cultural backgrounds (Solchanyk, et al., 2021; Tervalon & Murray-García, 1998).

Fig. 2. The Iceberg Metaphor in Relation to the Complexity of Culture

Kompetencje kulturowe + pokora kulturowa = refleksyjne kompetencje kulturowe

Developing cultural competence and engaging in cultural humility are ongoing processes that evolve in response to new situations, experiences, and relationships. Cultural competence serves as an essential foundation for practicing cultural humility. To achieve a higher level of care for patients from diverse cultural backgrounds, it is essential to integrate reflection and self-reflection processes, following a progression from cultural competence to cultural humility:

1. **Cultivating personal cultural awareness:** What defines my culture, and how does it shape the way I perceive and interact with others?
2. **Acquiring knowledge about cultures:** What are the characteristics of other cultures, and what unique strengths do they possess? What might be particularly important to individuals who identify with them?
3. **Recognizing and addressing power imbalances:** How can I use my understanding of my own culture and others' cultures to identify and work toward eliminating injustices in healthcare?
4. **Building healthcare based on humility:** What actions can I take to ensure that the care I provide moves toward greater inclusivity and equity? (Fig. 3).

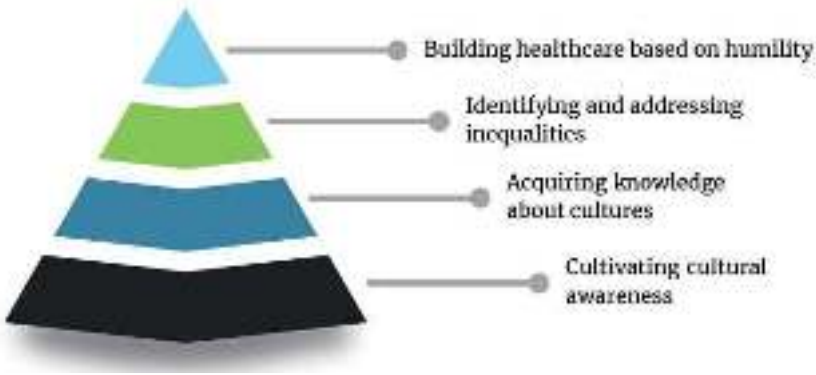


Fig. 3. Differentiating cultural humility from cultural competence

Cultural humility is grounded in several key principles that guide practitioners in their interactions with diverse populations. These principles emphasize self-reflection, the acknowledgment of power dynamics, and the development of respectful partnerships (Yeager & Bauer-Wu, 2013).

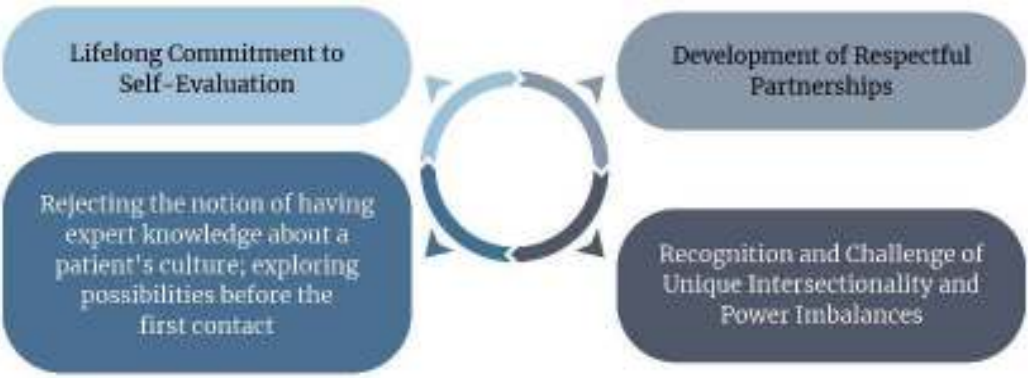


Fig. 4. Main Principles of Cultural Humility

Rejecting the notion of having expert knowledge about a patient's culture

In the context of multicultural education for students in medicine, nursing and other health sciences, an important aspect is the rejection of the idea of possessing "expert" knowledge about a patient's culture prior to the first contact. Contemporary approaches to cultural competence in healthcare emphasize that each patient is unique, with individual and changing cultural experiences. The practice of assuming there is one universal "expert" knowledge of a particular group's culture can lead to simplifications and stereotypes, which may negatively impact the quality of healthcare. A flexible and open approach to diverse patient identities is more effective, rather than adopting preconceived cultural knowledge. Instead, they should develop skills in asking questions,

listening, and engaging patients in the diagnostic and treatment process, allowing for the consideration of their individual cultural needs and experiences. Introducing strategies into medical education that focus on developing skills in understanding patients and exploring possibilities for interaction prior to the first encounter can help avoid the pitfalls of generalization.

Cultural understanding in the context of healthcare does not rely on mastering stereotypes, but rather on a continuous process of learning and adapting care to the needs of patients, which is crucial for achieving equity in healthcare (Betancourt, et al., 2003).

Furthermore, developing the ability to actively listen and demonstrate openness to cultural diversity should be a fundamental element of medical education, enabling effective interaction with patients from various social and cultural backgrounds (Zghal, et al., 2021).

Recognition and Challenge of Unique Intersectionality and Power Imbalances

Intersectionality examines how various social identities—such as race, gender, socioeconomic status, sexuality and much more—intersect to influence individuals' experiences and access to healthcare. Recognizing these overlapping identities enables healthcare professionals to understand the complexities of patient cultural backgrounds, leading to more personalized and effective care. Through the understanding and acceptance of intersectionality, medical education can move beyond traditional cultural competence models, fostering a deeper understanding of the multifaceted nature of patient identities. This approach not only enriches students' learning experiences but also contributes to reducing health disparities by promoting more inclusive and empathetic healthcare practices (Rehman, et al., 2023; Paniagua, 2024).

Cultural humility also involves a keen awareness of the inherent power imbalances that exist in practitioner-client relationships. Healthcare professionals must recognize that their roles come with authority and the potential to both provide and withhold essential services (So et al., 2023). By acknowledging these dynamics, practitioners can work towards creating a more equitable environment that fosters collaboration and respect. This principle emphasizes the importance of developing partnerships that empower clients and communities rather than perpetuating hierarchical relationships (Solchanyk, et al., 2021; Shah, et al., 2024).

Development of Respectful Partnerships

The third principle of cultural humility concerns the necessity of developing mutually beneficial partnerships with individuals and communities. This principle calls for practitioners to engage in relationships with patients from diverse cultural groups in a manner that respects autonomy, focusing on collaborative learning and shared decision-making (Paniagua, 2024; Gonzales-Walters, et al., 2024). By valuing the contributions and insights of others, practitioners can enhance their understanding of different cultures and create more inclusive practices that respond to the needs of each patient (So, et al., 2023).

Lifelong Commitment to Self-Evaluation

One of the foundational principles of cultural humility is a lifelong commitment to selfevaluation and self-critique. This principle acknowledges that understanding one's own cultural background and biases is an ongoing and dynamic process. A crucial element of working in healthcare is the necessity for critical self-reflection and analyzing how one's own experiences and values influence the shaping of interactions with others. This continuous self-assessment allows individuals to become more aware of their assumptions and challenge biases in their practice.

Together, these principles form the basis for implementing cultural humility in healthcare, ultimately leading to improved client outcomes and fostering a more inclusive environment in the medical and health sciences.

1.4. Professional Wellness as a Foundation for the Effectiveness of Multicultural Education for Medical and Health Sciences Students

Professional wellness encompasses a holistic approach to well-being that integrates multiple dimensions of health, including physical, emotional, occupational, social, spiritual, and intellectual aspects (Belthur et al., 2024). It is defined as the active and successful pursuit of activities, choices, lifestyles, traditions, and rituals that contribute to a state of holistic health (Chatterjee et al., 2022). This broad definition contrasts with the common belief that wellness is limited to physical health and fitness, urging a more inclusive consideration of all factors that influence individual and collective well-being in professional settings.

Professional wellness is a fundamental factor in the effectiveness of multicultural education, particularly in the fields of medical and health sciences. In the face of the rapidly growing diversity of societies in Europe, integrating intercultural competencies within professional well-being is essential to effectively address the diverse needs of patients, improve health outcomes, and maintain a high level of staff satisfaction.

The Impact of Increasing Demands on Healthcare Professionals' Well-being: Addressing Burnout and Cultural Competence in a Diverse Patient Environment

In recent years, healthcare systems across the globe have faced growing pressure to meet the needs of increasingly diverse patient populations. As demographic changes continue to shape societies, healthcare providers are increasingly required to deliver care that takes into account cultural differences, ethnic diversity, and social determinants of health. Although cultural competence plays a significant role in the training of healthcare professionals, there is growing recognition that the expectations associated with it may—unintentionally—contribute to increased emotional burden. As noted by Elbanna, et al. (2023), an excessive focus on the need to be "competent" in every cultural situation can create pressure and uncertainty, particularly in the context of an increasingly diverse patient population.

The increasing cultural diversity of patient populations requires healthcare professionals to be equipped with a broad set of skills, including cultural competence, to navigate complex interactions and ensure quality care. As healthcare systems adapt to serve diverse communities, healthcare workers are expected to possess a deep understanding of cultural nuances that influence patients' health beliefs, communication styles, and treatment preferences. However, this ever-expanding need for cultural competence is placing additional demands on medical professionals, who already face challenges such as long working hours, high stress, and the emotional toll of caregiving (Fan et al., 2024).

Research indicates that when healthcare professionals are required to maintain expert levels across various domains—including cultural competence—they experience higher levels of stress, anxiety, and burnout. The intense emotional labor re-

quired to interact with patients from different cultural backgrounds can take a toll on healthcare providers, leading to feelings of exhaustion, frustration, and disengagement (Shepherd et al., 2019). This risk is particularly high when cultural competence is evaluated in ways that emphasize deficiencies rather than strengths.

Cultural competence is widely regarded as essential for healthcare workers, enabling them to effectively engage with diverse populations. However, the tools commonly used to assess cultural competence, such as questionnaires and self-assessment forms, focus predominantly on identifying deficiencies. These assessments tend to highlight gaps in knowledge or perceived inadequacies in cultural understanding, reinforcing a deficit-based approach (Lin, et al., 2017). This method of evaluation can create a negative, high-pressure environment that undermines healthcare workers' sense of competence and well-being.

According to studies, such deficiency-based assessments often lead to increased stress levels among healthcare providers (Karatuna, et al., 2022). Rather than feeling empowered by the opportunity to enhance their cultural awareness, they may experience anxiety and insecurity about their perceived inadequacies. In turn, this stress can manifest in a range of detrimental emotional responses, including withdrawal from patient interactions or avoidance of patients from different cultural backgrounds. In more extreme cases, healthcare providers may display passiveaggressive behaviors, such as frustration or resentment, which further undermines the quality of patient care.

The Psychological Impact of Deficit-Based Evaluation

A key problem with the current approach to cultural competence assessment is its tendency to foster an environment of self-criticism and shame. Healthcare professionals, when presented with assessments that highlight their shortcomings, may internalize feelings of failure, which can exacerbate stress and contribute to burnout. This approach, rather than motivating improvement, often leads to disengagement, avoidance, and frustration. A growing body of evidence suggests that this negative psychological impact may result in a vicious cycle of burnout, where healthcare workers feel increasingly incapable of meeting the diverse needs of their patients (Tajfel & Turner, 1986).

One study found that physicians and nurses who were regularly subjected to assessments that pointed out their cultural competence deficiencies they were more susceptible to experiencing stress and anxiety. These emotional responses, if left unaddressed, can erode the quality of care provided to patients and lead to diminished job satisfaction among healthcare workers. Furthermore, the emotional toll of cultural competence training, when not handled properly, can contribute to the rising incidence of burnout in healthcare professionals (Tanios, et al., 2021).

1.5. EMPOWER Model - Developing Reflective Cultural Competencies Among Healthcare Professionals in an Environment Supporting Health and Well-being

The EMPOWER Model focuses on fostering professionals' growth in a health and wellnesssupportive environment.

The EMPOWER Model proposes addressing not only the needs of patients from diverse cultural backgrounds but also recognizing and appreciating the needs of students and healthcare workers within the context of a comprehensive approach to developing cultural competence and cultural humility (Elbanna, et al., 2023). It emphasizes the need to create a learning environment that supports the health and well-being of students, while also focusing on ensuring a sense of safety during the development of reflective cultural competence, fostering intrinsic motivation, providing social support, and enhancing the effectiveness of educational actions (Fig. 5).

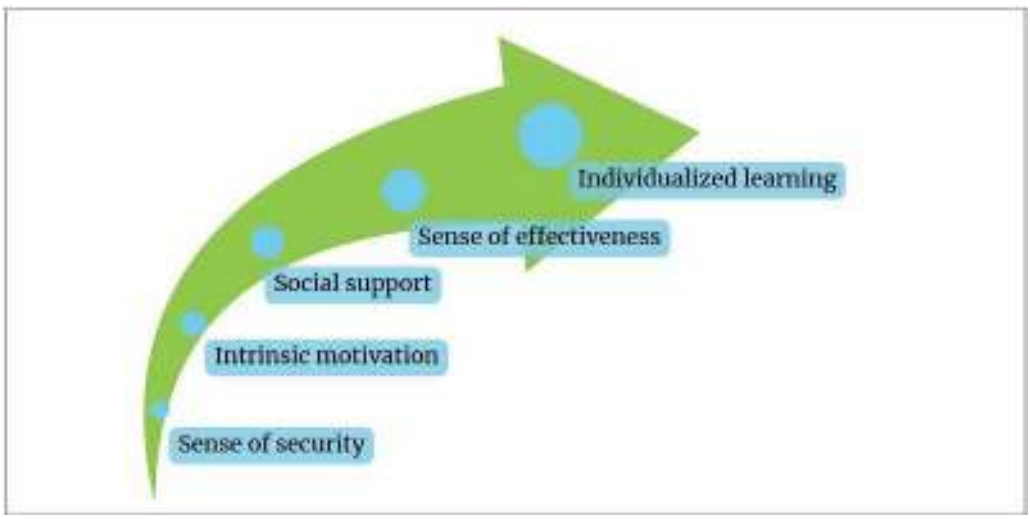


Fig. 5. EMPOWER Model - developing professionals in a health and wellness supportive environment

You can't know everything about other cultures! That's a fact. It's enough if you're open to dialogue and others' perspectives.

One of the fundamental aspects of the EMPOWER model is the creation of an **environment in which participants feel safe** while acquiring new competencies, particularly those related to sensitive issues such as stereotypes and diversity. A secure educational setting encourages participants to express their questions and uncertainties without fear of judgment, fostering deeper engagement in the learning process. Acknowledging and accepting that it is impossible to acquire complete knowledge of all cultures enables the development of an attitude that embraces awareness of one's own limitations and openness to dialogue. This safe educational environment promotes a readiness for continuous learning and receptiveness to diverse perspectives.

Intrinsic motivation plays a crucial role in ensuring the effectiveness of multicultural training, particularly in the context of learners' well-being. When participants are intrinsically motivated, their engagement in the learning process becomes more authentic and sustained. Intrinsic motivation, defined as the desire to learn driven by personal interest in the subject, a sense of the value of education, and a wish for selfdevelopment, fosters a deeper understanding and assimilation of issues related to cultural diversity. This type of motivation leads to a more reflective approach to the subject matter, encouraging the development of an open mindset towards different perspectives and sensitivity to the needs and experiences of others. Furthermore, when participants feel that they have a genuine influence on their own development, and the learning process aligns with their values and interests, their psychological and emotional well-being improves. As a result, the effectiveness of multicultural training is not only about acquiring knowledge but also about creating an environment that supports personal growth, openness to others, and the maintenance of participants' well-being.

Social support is an integral component of effective learning, and within the EMPOWER Model, it plays a crucial role in the process of acquiring reflective cultural competencies. Support provided by teachers, mentors, and peer groups fosters an environment conducive to collaboration and mutual trust, which is essential for professional development in the healthcare sector. The teacher acts as a guide and support, not only imparting knowledge but also encouraging reflection on one's own biases, stereotypes, and attitudes. The student group, in turn, forms a community where participants can share their experiences, successes, and challenges related to the development of cultural competencies. Through this collaboration, individuals feel less isolated in the learning process, which allows for the building of stronger connections with others and enhances motivation for continued personal and professional growth.

A key aspect of the EMPOWER model is fostering a **sense of effectivenessand efficiency** in participants' efforts. The research findings indicate that individuals who believe in their ability to achieve their goals are more motivated and engaged in the learning process. Therefore, this model emphasizes the regular provision of feedback to participants, highlighting progress rather than solely pointing out deficiencies. In the EMPOWER model, progress assessment is based on positive reinforcement. An important element is also the opportunity for participants to independently track their progress, which strengthens their sense of control over the learning process and the effectiveness of their actions.

One of the key features of the EMPOWER Model is the provision of an **individualized educational pathway** that integrates highly engaging tools aimed at improving both cultural competence and cultural humility among students and healthcare professionals.

The individualized educational pathway allows each participant to progress at their own pace, considering their unique background, learning style, and specific needs. This approach is essential for promoting deep, meaningful learning in

the context of of cultural competence, where no single method works universally. Healthcare professionals and students come from diverse educational backgrounds and have varied experiences, and their willingness to engage in the study of multiculturalism may vary significantly. Offering such a learning method ensures that each participant has the opportunity to independently pursue the appropriate level of challenges and support, making the learning experience relevant and impactful. The individualized pathway within the EMPOWER Model includes a range of flexible modules, for self-paced learning and at their own scope, and assignments that focus on the practical application of cultural knowledge. This pathway is designed to be adaptive, allowing participants to revisit difficult topics and take on more challenging activities as they progress, while ensuring social support (from instructors or peer groups) throughout the learning process.

The goal is to equip healthcare professionals with the openness needed to enhance their cultural awareness, while promoting the development of cultural humility—recognizing one's limitations in understanding other cultures and being open to learning from others.

To support the individualized educational pathway, the EMPOWER Model integrates a range of engaging tools aimed at improving cultural competence and promoting cultural humility. These tools are designed to capture the participants' attention and actively engage them in the learning process. The exercises proposed in this guide are integrated with a digital platform, allowing for the use of modern technology to support the educational process. The proposed tasks and exercises serve various functions, but all contribute to the overarching goal of enabling students and healthcare professionals to engage meaningfully with cultural diversity.

The EMPOWER Model does not view cultural competence and cultural humility as final goals but as ongoing processes of personal and professional development. The individualized educational pathway, along with its engaging tools, supports continuous growth by providing participants with opportunities to revisit materials, reflect on their experiences, and set new educational goals. This approach encourages them to engage in lifelong learning, enabling them to meet the evolving needs of diverse patient populations with empathy, respect, and cultural sensitivity.

The ultimate goal of the EMPOWER Model is to create an environment where healthcare professionals feel supported, competent, and confident in their ability to provide culturally competent care. By providing a personalized, engaging educational experience that focuses on cultural competence and humility, the EMPOWER Model ensures that healthcare professionals are not only prepared to face the challenges of a multicultural world but also equipped with the tools to succeed in it. This process improves the well-being of individuals as well as their professional effectiveness, bringing benefits not only to the participants themselves but also to the patients and communities they care for.

The EMPOWER Model presents an innovative approach to healthcare education, emphasizing support for the health and well-being of professionals as they de-

velop cultural competence. By ensuring a sense of security, fostering intrinsic motivation, providing social support, building a sense of effectiveness, and incorporating engaging educational tools, the EMPOWER Model promotes comprehensive professional development. As a result, healthcare professionals become more competent and confident when working with patients from diverse cultural backgrounds, leading to higher quality care and better relationships with patients.

1.6. EMPOWER MODEL - Education Resources

The EMPOWER Model presents a transformative approach to multicultural education, one that is centered around fostering both cultural competence and humility among healthcare professionals. This model emphasizes the importance of developing educational resources that not only provide knowledge but also ensure a sustainable and impactful learning journey. The EMPOWER Model is rooted in a clear, purposeful framework designed to meet the evolving needs of both learners and the diverse patient populations they serve.

1. *Initiation of effective multicultural education (Defining Clear, Purposeful Outcomes)*
2. *Effective Learning Design (Creating a Holistic and Inclusive Experience)*
3. *Engaging in Practical Application (Ensuring Relevance to Professional Practice)*
4. *Transforming and Strengthening Knowledge Transfer (Applying Knowledge in Diverse Environments)*
5. *Reinforcing and Supporting Learning Progress (Continuous reinforcement throught assessment and Feedback Mechanisms)*
6. *Acting and Documenting Impact(Maintaining Long-Term Improvements)*

Initiation of effective multicultural education: Defining Clear, Purposeful Outcomes

The initiation of effective multicultural education within the EMPOWER model begins with the key task of **defining clear, purposeful outcomes** that guide the teaching process. The first step in this approach is setting goals that are not only academic but also holistic, emphasizing a deep understanding of the cultural dynamics that influence healthcare. These goals are designed to encourage participants to explore how cultural factors affect communication with patients, the delivery of healthcare, and professional interactions in an increasingly global context. By defining these educational objectives, the EMPOWER model aims to create a comprehensive framework that prepares healthcare professionals to navigate the complexities of multicultural environments, promoting a more culturally competent and empathetic approach to care.

A key element of this educational foundation is the integration of reflection and critical awareness, which allows participants to engage with their own cultural biases and assumptions. This self-awareness is crucial for recognizing how per-

sonal beliefs andunconscious prejudices may influence professional practices, particularly when interacting with diverse patient groups. Thanks to organized activities that encourage self-reflection, participants are encouraged to explore how their cultural filters shape their responses to patients and colleagues, fostering a mindset open to growth and adaptation. This reflective practice is essential for cultivating cultural humility, ensuring that healthcare professionals remain aware of the limitations of their understanding of other cultures and are committed to continuous learning.

Effective Learning Design: Creating a Holistic and Inclusive Experience

The design of an effective learning process emphasizes the creation of an educational framework that fosters a holistic and inclusive environment for healthcare professionals. A key element of this approach is the understanding that diversity is not merely an external factor to be addressed, but a fundamental component of the teaching process itself. The EMPOWER model highlights the importance of curriculum development that integrates case studies, research, and field experiences, drawn from various cultural perspectives in healthcare. By incorporating diverse cultural viewpoints, the curriculum ensures that healthcare professionals are exposed to the complexities of global health challenges, better preparing them to provide care to diverse patient populations with sensitivity and competence.

The EMPOWER model further enhances the learning experience by incorporating principles of transformative learning, which aims to shift participants' perspectives and challenge their assumptions. Central to transformative learning are three key components:

- Disorienting Dilemma,
- Critical Reflection,
- Dialogue and Action.

A Disorienting Dilemma refers to activities or exercises designed to challenge participants' pre-existing beliefs, encouraging them to confront their biases and reconsider their views. These dilemmas push learners out of their comfort zones, stimulating deep, critical thinking. **Critical Reflection** is the process through which participants analyze and evaluate their beliefs and values, particularly in relation to cultural dynamics in healthcare. This self-awareness fosters recognition of how personal beliefs and values influence interactions with patients and colleagues. Finally, **Dialogue and Action** emphasize the importance of engaging in conversations with people from diverse backgrounds, which leads to transformed perspectives and the practical application of new approaches in professional practice. These three components work synergistically to create a transformative educational environment that is not only intellectually enriching but also impactful on personal and professional development (Mezirow, 1991).

In addition to these foundational elements, the EMPOWER model promotes **Experiential Learning for Empathy Building**. This approach emphasizes the value of immersive learning experiences, such as community outreach programs, simulations with patients from diverse cultural backgrounds, and cultural exchanges. These activities allow healthcare professionals to experience firsthand the challenges and complexities of working with diverse populations, thereby enhancing their cultural awareness and empathy. Through these experiences, participants develop a deeper understanding of the lived experiences of others, which is essential for building compassionate, patient-centered care.

In order to expand the scope of applying the principles of Experiential Learning to build empathy, the EMPOWER model combines the theoretical part, found in the manual, with the Educational Platform of the MultiCultiMed program, which includes the "Human Library." This is an innovative educational resource that allows students to engage with interviews conducted with individuals from diverse cultural groups, often exposed to discrimination or marginalization. The goal of this tool is to foster empathy and deepen the understanding of others' perspectives, particularly those representing minority social, ethnic, religious, and cultural backgrounds. The interviews, filled with personal stories, experiences, and reflections, provide educational participants with insights into the lives of people from different cultures, contributing to broadening their horizons, reducing prejudices, and developing interpersonal skills essential for working with diverse patients. The "Human Library" creates a learning space through listening and deeper understanding, supporting the development of cultural competencies.

Equally important in effective learning design is active participation in the learning process. The EMPOWER model encourages participants to actively engage with their learning, especially through seeking interactions with peers from diverse backgrounds. Such experiences promote mutual respect and the shared acquisition of cultural knowledge, enabling participants to learn from each other's perspectives. Active participation supports a sense of community and belonging, which is essential for creating a positive and inclusive educational atmosphere. Additionally, it fosters critical thinking, problem-solving, and teamwork, all of which are essential skills for professional practice in a multicultural context.

Engaging in Practical Application: Ensuring Relevance to Professional Practice

The EMPOWER Model places significant emphasis on the application of acquired cultural competencies to practical use in professional work settings. This aspect focuses on bridging the gap between theoretical knowledge and practice. The goal is not only for students to acquire theoretical knowledge but also to develop the necessary skills to effectively apply it in a professional environment. The model incorporates a series of exercises simulating real-life experiences, supported by peer interactions, in order to integrate diverse perspectives and collaboratively seek solutions. Activities such as role-playing, intercultural communication exercises, and problem-solving simulations related to patient care from diverse cultural backgrounds aim to prepare students for challenges they may encounter in multicultural healthcare environments. By simulating real-life scenarios, students are encouraged to apply their knowledge in a dynamic and supportive environment, which helps them better understand the complexities of patient care in various cultural contexts, fostering the development of critical thinking and problem-solving skills.

The EMPOWER Model also emphasizes the importance of peer learning and feedback in the process of continuous improvement. By incorporating peer feedback systems and discussions, students have the opportunity to learn from the experiences and perspectives of others. This collaborative approach promotes a deeper understanding of multicultural issues in healthcare while developing a culture of self-reflection and constructive critique. Peer feedback provides students with valuable insights into their own practices, helping them identify areas for growth and encouraging them to continually refine their reflective cultural competencies. This process not only strengthens students' ability to engage with diverse patient populations but also fosters an environment of mutual support and learning within the educational community.

Transformation and Strengthening of Knowledge Transfer: Applying Knowledge in Diverse Environments

In the EMPOWER model, the aspect of Transformation and Knowledge Transfer Enhancement focuses on providing a selection of exercises and tasks that increase the likelihood that students will not only acquire theoretical knowledge but also gain the necessary preparation to apply it in various real-world healthcare settings.

A key role in strengthening knowledge transfer and supporting professional development is played by the teacher-mentor and the student group. Mentors, who serve as models of best practices in culturally competent healthcare, can offer students guidance, support, and examples of effective patient care in diverse settings. The support provided within the student group facilitates the sharing of experiences and access to feedback. The combination of mentorship from the teacher and support within the student group creates a collaborative learning environment where students can refine their skills, enhance their practice, and gain confidence in providing culturally competent care.

Empowering Growth: Teachers' Role in Feedback and Evaluation Mechanisms

The EMPOWER Model places great emphasis on **continuously reinforcing and supporting students** throughout their multicultural education journey in healthcare. This aspect focuses on the systematic evaluation of learning outcomes, not to highlight deficiencies or criticize mistakes, but to ensure ongoing development. The application of feedback loops and supportive evaluation tools can help track progress, identify areas requiring additional support, and ensure that multicultural competencies are being effectively developed in students. Providing students with constructive feedback on their progress allows them to refine their approaches to culturally diverse healthcare by identifying areas where they can improve, learning from their mistakes, and enhancing their communication skills. This ongoing process of feedback and reflection is an integral part of creating a learning environment based on continuous development, in which students feel supported in their efforts to enhance their reflective cultural competencies.

An essential aspect is also the development of the teaching staff responsible for training medical and health science students in multiculturalism. The MultiCultiMed educational platform provides access to resources dedicated to teachers. Its purpose is not only to provide substantive guidance but also practical tips and tools that will help them effectively conduct classes, engage students, and monitor progress in developing cultural competencies.

The MultiCultiMed platform can serve as a guide, offering teachers detailed instructions on exercise methodologies and organizing discussions in a group of students. Teachers have access to interactive and engaging teaching methods that foster the development of multicultural competencies among students. Additionally, it provides guidelines on interpreting the results of exercises, tests, and assessments related to multicultural education. Furthermore, the platform provides teachers with a wide range of discussion topics that can be introduced during classes, helping students approach cultural issues more consciously. The content of the platform for teachers will not only provide them with access to engaging educational materials but it can also become a part of their own professional development process.

Maintaining Long-Term Improvements

The EMPOWER Model emphasizes the crucial role of deeply engaging and activating exercises in creating lasting changes in the way healthcare students perceive and address the challenges associated with multiculturalism in patient care. Specifically, the model promotes educational approaches that go beyond theoretical teaching, offering engaging, practical experiences that foster real-world applications of multicultural competencies in professional work. Through deep student engagement in practical exercises and scenarios based on reflective cultural competencies, the EMPOWER model ensures that the skills and knowledge they acquire are not merely taught, but internalized, leading to long-term changes in their understanding and approach to healthcare in diverse cultural contexts.

A central aspect of this approach is Long-Term Impact Assessment, which aims to measure the effectiveness of the program in improving students' multicultural competence and professional wellness over time. Program administrators plan to implement a system for gathering feedback from program graduates, providing data on how the competencies acquired during the program are applied in their professional practice.

Additionally, a significant element of the EMPOWER Model is its global relevance and adaptation to the evolving realities of medical practice. The content offered to students and teachers is adaptable to a wide range of healthcare environments worldwide, focusing not only on theoretical learning but also on the practical application of multicultural competencies in diverse, real-world conditions. In practice, this means creating flexible structures that can be tailored to the specific needs of different healthcare systems and regions around the world.

We believe that the strength of the EMPOWER Model, enabling long-term improvements in multicultural education, lies in the global adaptability of the proposed exercises and content. Through deeply engaging educational techniques and a flexible approach that responds to the needs of various cultural and professional environments, the EMPOWER Model not only helps students develop the necessary skills for providing culturally competent care but also supports continuous growth and reflection. These strategies ensure that the program's impact extends far beyond the classroom, leading to lasting improvements in healthcare practices globally.

Summary of the Core Principles of the EMPOWER Model Educational Resources

The EMPOWER Model for multicultural education in healthcare and medical studies is built on foundational principles that prioritize the comprehensive and sustainable development of cultural competence. These principles focus on the complexity of healthcare environments and aim to equip students with the knowledge and tools necessary to effectively serve diverse patient populations.

Intersectionality is a key concept that underpins the model, recognizing the interconnected and unique identities of both students and patients. By highlighting how overlapping identities—such as race, gender, socioeconomic status, cultural background, and many others—affect health outcomes, the model promotes a deeper understanding of the diverse needs within patient populations. Students are encouraged to consider how these intersecting identities impact their approach to patient care and to develop more holistic and nuanced strategies that address individual needs within a multicultural context.

Critical Reflection is another central principle of the EMPOWER Model, encouraging students to examine their own biases, cultural perceptions, and professional behaviors. Through structured reflection, students are prompted to identify how these personal factors influence their interactions with patients and their overall approach to care. This process helps students become more aware of their assumptions and blind spots, fostering a mindset of continuous self-assessment and improvement in medical practice. Through critical reflection, students can challenge their preconceptions and refine their cultural competence, ensuring more empathetic and inclusive patient care.

Core Principles of the EMPOWER MODEL Educaltional resources:
- *Intersectionality*
- *Critical Reflection*
- *Actionable Knowledge*
- *Continuous Growth and Wellness*

Actionable Knowledge is an approach focused on equipping students with practical skills, methods, and tools that can be immediately applied in healthcare practice. This principle ensures that students not only learn theory but also gain the hands-on knowledge necessary to address the daily challenges of working in a multicultural environment. By providing students with actionable, evidence-based strategies, the model supports the delivery of culturally competent care, improving patient health outcomes and enhancing cross-cultural communication.

Finally, **Continuous Growth and Wellness** is a principle that serves as the foundation for the long-term success and resilience of healthcare professionals. The model acknowledges that navigating challenges in multicultural healthcare can be mentally and emotionally demanding, and aims to support students in developing the resilience and mental wellness necessary for career success. This emphasis on personal development goes beyond cultural competencies, ensuring that students are aware of the immense importance of effective stress management, maintain psychological balance, and foster a sustainable professional life throughout their careers.

1.7. EMPOWER MODEL - Supportive Tools

Tools supporting students in developing cultural competence and cultural humility are designed to be constructive, reflective, and to foster growth, rather than focusing on negative aspects, pointing out deficiencies, or criticism. The goal is to create a learning environment that is safe, empathetic, and focused on continuous development. The MultiCultiMed educational platform provides a space for **reflective journaling**. The purpose of such a journal is to encourage students to regularly reflect on their experiences, challenges, and progress in learning about culture and diversity. Journals can be used in various and flexible ways, depending on individual needs. For example, students can keep journals where they note their thoughts on interactions with patients from different cultures, their feelings about learning diversity, and identify areas requiring further development. An important aspect is also recording successes and positive experiences, which indicate progress. The MultiCultiMed platform makes it easy to record thoughts and offers access to pre-made reflective questions that help students delve deeper into their experiences (e.g., questions such as: "What challenges did I face in this situation? What can I improve next time? What did I do well?" etc.).

The platform also includes reflective tasks with 360° feedback, allowing students to receive feedback from various individuals (e.g., peers, teachers, patients, observers), which helps them better understand their development in the context of cultural diversity.

These tools are designed to promote honest and sincere reflection on personal development, without stigmatizing mistakes. They focus on supporting the learning process, identifying areas for improvement, but also on celebrating successes that motivate further self-improvement. An important element is creating a space where students feel safe, have the opportunity to explore their own attitudes and beliefs, and are encouraged to continuously grow, both in terms of cultural competence and personal humility.

References

Belthur, M. V., Federico-Martinez, G., Drane, D., & Hartmark-Hill, J. (2024). Physician leadership behaviors and strategies: Insights to integrate and prioritize faculty well-being. *Physician Leadership Journal*, 11(5), 12-19. https://doi.org/10.55834/plj.1067073980

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O. 2nd. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*, 118(4), 293-302. https://doi.org/10.1093/phr/118.4.293

Chatterjee, K., Edmonds, V. S., Girardo, M. E., Vickers, K. S., Hathaway, J. C., & Stonnington, C. M. (2022). Medical students describe their wellness and how to preserve it. *BMC Medical Education*, 22(1), 510. https://doi.org/10.1186/s12909-022-03552-y

Elbanna, M. F., Thomas, M. R., Patel, P. R., & McHenry, M. S. (2023). Cultivating cultural humility to address the healthcare burnout epidemic—Why it matters. *Global Advances in Integrative Medicine and Health*, 212, 27536130231162350. https://doi.org/10.1177/27536130231162350

Fan, J., Chang, Y., Li, L., Jiang, N., Qu, Z., Zhang, J., Li, M., Liang, B., & Qu, D. (2024). The relationship between medical staff burnout and subjective wellbeing: The chain mediating role of psychological capital and perceived social support. *Frontiers in Public Health*, 12, 1408006. https://doi.org/10.3389/fpubh.2024.1408006

Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2015). From mastery to accountability: Cultural humility as an alternative to cultural competence. *Social Work Education*, 34(2), 165–181. https://doi.org/10.1080/02615479.2014.977244

Foronda, C., Baptiste, D., Reinholdt, M., & Ousman, K. (2016). Cultural humility: A concept analysis. *Journal of Transcultural Nursing*, 27(3), 210–217. https://doi.org/10.1177/1043659615592677

Gonzales-Walters, F., Weldon, S., & Essex, R. (2024). Cultivating cultural humility through healthcare simulation-based education: A scoping review protocol. *International Journal of Healthcare Simulation*, 1, 1-7. https://doi.org/10.54531/rafh4191

Greene-Moton, E., & Minkler, M. (2019). Cultural competence or cultural humility? Moving beyond the debate. *Health Promotion Practice*, 20(1), 142–145. https://doi.org/10.1177/1524839919884912

Karatuna, I., Owen, M., Westerlund, H., & Berthelsen, H. (2022). The role of staff-assessed care quality in the relationship between job demands and stress in human service work: The example of dentistry. *International Journal of Environmental Research and Public Health*, 19(19), 12795. https://doi.org/10.3390/ijerph191912795

Lekas, H. M., Pahl, K., & Fuller Lewis, C. (2020). Rethinking cultural competence: Shifting to cultural humility. *Health Services Insights*, 13, 1178632920970580. https://doi.org/10.1177/1178632920970580

Lin, C. J., Lee, C. K., & Huang, M. C. (2017). Cultural competence of healthcare providers: A systematic review of assessment instruments. *Journal of Nursing Research*, 25(3), 174-186. https://doi.org/10.1097/JNR.0000000000000153

Liu, J., Miles, K., & Li, S. (2022). Cultural competence education for undergraduate medical students: An ethnographic study. *Frontiers in Education, Second Language, Culture and Diversity*, 7. https://doi.org/10.3389/feduc.2022.980633

Majda, A., Zalewska-Puchała, J., Bodys-Cupak, I., Kurowska, A., & Barzykowski, K. (2021). Evaluating the effectiveness of cultural education training: Cultural competence and cul-

tural intelligence development among nursing students. *International Journal of Environmental Research and Public Health*, 18(8), 4002. https://doi.org/10.3390/ijerph18084002

Mezirow, J. (1991). *Transformative dimensions of adult learning*. Jossey-Bass.

Paniagua, F. A. (2024). *Teaching cultural competence and cultural humility in medical education: A practical guide* (1st ed.). CRC Press. https://doi.org/10.1201/9781003529057

Pawlak-Sobczak, K. (2019). Model systemowo-partnerski w relacji personel medycznypacjent obcokrajowiec. Możliwości versus bariery (The systemic-partner model in the medical personnelforeign patient relationship: Opportunities vs. barriers). *Władza Sądzenia*, 16, 67-95. https://doi.org/10.18778/2300-1690.16.05

Rehman, M., Santhanam, D., & Sukhera, J. (2023). Intersectionality in medical education: A metanarrative review. *Perspectives on Medical Education*, 12(1), 517-528. https://doi.org/10.5334/pme.1161

Shah, D., Behravan, N., Al-Jabouri, N., & Sibbald, M. (2024). Incorporating equity, diversity and inclusion (EDI) into the education and assessment of professionalism for healthcare professionals and trainees: A scoping review. *BMC Medical Education*, 24, 991. https://doi.org/10.1186/s12909-024-05981-3

Shepherd, S. M., Willis-Esqueda, C., Newton, D., Sivasubramaniam, D., & Paradies, Y. (2019). The challenge of cultural competence in the workplace: Perspectives of healthcare providers. *BMC Health Services Research*, 19, 135. https://doi.org/10.1186/s12913-019-3959-7

So, N., Price, K., O'Mara, P., & Rodrigues, M. A. (2024). The importance of cultural humility and cultural safety in health care. *The Medical Journal of Australia*, 220(1), 12-13. https://doi.org/10.5694/mja2.52182

Solchanyk, D., Ekeh, O., Saffran, L., Burnett-Zeigler, I. E., & Doobay-Persaud, A. (2021). Integrating cultural humility into the medical education curriculum: Strategies for educators. *Teaching and Learning in Medicine*, 33(5), 554-560. https://doi.org/10.1080/10401334.2021.1877711

Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, 9(2), 117-125. https://doi.org/10.1353/hpu.2010.0233

Verbree, A. R., Isik, U., Janssen, J., & Dilaver, G. (2023). Inclusion and diversity within medical education: A focus group study of students' experiences. *BMC Medical Education*, 23, 61. https://doi.org/10.1186/s12909-023-04036-3

Yeager, K. A., & Bauer-Wu, S. (2013). Cultural humility: Essential foundation for clinical researchers. *Applied Nursing Research*, 26(4), 251–256. https://doi.org/10.1016/j.apnr.2013.06.008

Zanetti, M. L., Dinh, A., Hunter, L., Godkin, M. A., & Ferguson, W. (2014). A longitudinal study of multicultural curriculum in medical education. *International Journal of Medical Education*, 5, 37-44. https://doi.org/10.5116/ijme.52ec.d075

Zghal, A., El-Masri, M., McMurphy, S., & Pfaff, K. (2020). Exploring the impact of health care provider cultural competence on new immigrant health-related quality of life: A cross-sectional study of Canadian newcomers. *Journal of Transcultural Nursing*, 32(5), 508-517. https://doi.org/10.1177/1043659620967441

Multi Culti Med

Chapter 2

Diversity and Inclusion in Healthcare

Małgorzata Zimny
Pomeranian Medical University in Szczecin (Poland)

> **Diversity and inclusion in healthcare are not merely guiding principles but fundamental pillars that ensure every patient feels recognized, heard, and respected—because true health begins with equity.**

2.1. Introduction

Diversity and inclusion have long been widely used terms in various contexts, but only in recent years have they become integral to discussions on healthcare.

A rich diversity, reflecting the mosaic of communities in terms of race/ethnicity, gender, sexual orientation, immigration status, physical disability, and socioeconomic level, can present challenges for healthcare providers and patients alike. However, it also offers opportunities for positive transformation. For such transformation to be successful, efforts must focus on diversity, equity, and inclusion rather than just diversity alone. There is a growing understanding of the interconnection between the work environment of healthcare providers, patient outcomes, and overall organizational performance (Gill, 2018).

Diversity and inclusion in healthcare involve incorporating different perspectives, cultures, experiences, and identities into everyday medical practice. This approach requires acceptance and respect for racial, ethnic, cultural, gender, age, and religious diversity, as well as an understanding of the challenges faced by individuals with disabilities or those belonging to marginalized social groups. The key objective is to ensure equal opportunities, access, and high-quality healthcare for everyone, regardless of their background or life circumstances (Stanford, 2020).

Aims

In this chapter, students will develop their knowledge and skills in the following areas:

- Understanding the benefits of diversity and inclusivity in healthcare
- Identifying strategies for overcoming barriers associated with working in a culturally diverse environment
- Recognizing key areas of professional behavior in the context of cultural diversity
- Understanding the importance of key characteristics required by healthcare personnel to work effectively in a culturally diverse environment

Learning Outcomes

Upon completing this chapter, readers will be able to:

- Recognize and appreciate the benefits of cultural diversity in healthcare;
- Identify methods for overcoming barriers to healthcare access;
- Tailor medical care to individual patient needs by implementing key areas of professional behavior in the context of cultural diversity;
- Collaborate effectively in a culturally diverse medical environment by understanding and developing the key characteristics required of healthcare personnel.

2.2. The Benefits of Diversity and Inclusion in Healthcare

Modern healthcare operates in an increasingly diverse society, where patients come from various cultural, social, and linguistic backgrounds. Embracing this diversity not only enhances the quality of services provided but also fosters trust between patients and healthcare providers. An inclusive approach to healthcare allows for better tailoring of diagnosis and treatment to the individual needs of patients, reducing barriers to access, and improving treatment outcomes.

2.2.1. Better Health Outcomes

Understanding cultural differences helps to better recognize the individual needs of patients, allowing for a more precise alignment of medical care with their expectations and life circumstances. This enables doctors and medical staff not only to diagnose and treat more effectively but also to build relationships based on trust, which increases the effectiveness of therapies and enhances patient comfort.

Better communication with patients significantly impacts the success of treatment. Using translators or educational materials tailored to the patient's language and culture facilitates their understanding of medical instructions. This allows patients to better follow therapeutic guidelines, improving the effectiveness of treatment and enhancing health outcomes (Borowczyk, 2023). The growing awareness of the importance of effective communication in healthcare systems is becoming increasingly common. Given that communication courses must be tailored to the specifics of a particular culture, language, and other contextual issues, many countries and communities using a common language have proposed their recommendations for communication curricula in undergraduate medical studies. With the increasing awareness of the importance of medical communication, its teaching has been integrated into the core medical curriculum. Medical faculties worldwide began introducing appropriate courses into their curricula by the end of the 20th century. One of the first experiences came from the University of Lagos in 1984 (Ersek, 2020). More contemporary examples include Leipzig University Medical School - COMSKIL Communication Skills Training (Gebhardt, 2021) and Longitudinal Communication Curriculum (Zimmermann, 2021), Charité - Universitätsmedizin Berlin, Ghent University (Kienle, 2021), and Harvard Medical School (Rider, 2006).

One strategy that many organizations have already implemented is translation services, which are crucial for patients with limited local language proficiency and for the development of written materials (Karliner, 2007). Another strategy to improve cultural competence is the inclusion of patient navigators, staff, and patient advocates. The most effective solution is, if possible, to employ medical staff who culturally best match the majority of the patients under care (Nair, 2019).

Reducing Health Inequalities: In the literature on the subject, the aspect of equality is most often emphasized, understood as ensuring equal rights for individuals with the same healthcare needs (Equal access for equal needs) (Culyer, 1995). Di-

versity in healthcare enables better identification and elimination of barriers that restrict access to medical services, such as language, financial, or social barriers. This may include collaboration with community organizations, immigrant and refugee organizations, as well as other social groups, such as non-governmental organizations, foundations, associations, religious groups, and social clubs.

Preventing Medical Errors: Understanding the cultural context of a patient can help prevent misunderstandings that sometimes lead to incorrect diagnoses or treatments (Puch, 2020).

2.2.2. Greater Patient Trust in the Healthcare System

Building Trust-Based Relationships: Trust is the foundation of effective healthcare, and patients who feel that their culture, values, and traditions are respected are more likely to be open and cooperate with healthcare providers. When doctors, nurses, and other healthcare professionals demonstrate understanding of the individual needs of patients, taking into account their cultural and social background, patients feel more accepted and treated with respect. This approach helps build a stronger bond between the patient and medical staff, leading to better communication and more effective treatment.

Respect for cultural diversity and building trust in healthcare not only strengthens the relationship between the patient and the provider but also improves treatment outcomes and the overall quality of care.

For example, if a patient from a particular culture has concerns about treatments or procedures that conflict with their traditions, healthcare personnel who demonstrate understanding and provide appropriate education can help alleviate those concerns by acknowledging, appreciating, and offering both emotional and informational support. Respect for the patient's culture also impacts their sense of safety, which can reduce resistance to seeking medical consultations. Patients who feel that their identity is accepted are more likely to engage in long-term care, adhere to medical recommendations, and actively participate in the treatment process.

Furthermore, this approach helps reduce language and cultural barriers that may hinder effective communication and create a distance between the patient and healthcare providers. As a result, building relationships based on trust and cultural diversity not only improves patient satisfaction but also enhances treatment effectiveness, reduces the risk of medical errors, and contributes to the overall improvement of healthcare quality.

Reduction of Anxiety and Stress: When patients feel understood, respected, and valued, their emotional response to healthcare situations improves significantly. Anxiety and stress are common reactions to medical interventions, especially when patients feel a lack of understanding from their providers due to differences in communication styles, cultural backgrounds, or lack of empathy (Rozlog, 1999). However, when healthcare workers take the time to understand the unique

needs, concerns, and cultural context of the patient, they create an environment where the patient feels heard and safe. This sense of understanding fosters a positive therapeutic relationship, leading to greater openness and willingness to cooperate with the healthcare team. When patients feel more comfortable, they are more likely to openly discuss their symptoms, treatment preferences, and concerns, allowing healthcare workers to provide more personalized care. This, in turn, improves the overall patient experience during treatment. Moreover, the reduction of anxiety and stress has a direct impact on health outcomes. High levels of stress can hinder the healing process as it negatively affects the immune system and exacerbates certain conditions. When patients feel less stressed, they are more likely to adhere to medical recommendations, follow treatment plans, and engage in proactive health management, which contributes to faster recovery. In essence, nurturing a sense of understanding not only creates a more positive and collaborative environment but also accelerates the healing process by alleviating emotional and mental burdens that may impede recovery (Sirois, 2018).

When patients feel understood and supported, it reduces stress and anxiety, fostering cooperation, which improves treatment outcomes and accelerates the healing process.

2.2.3. Increasing the Effectiveness of the Medical Team

Culturally Diverse Teams Are More Creative: Cultural diversity within teams brings together individuals with different perspectives, experiences, and problem-solving approaches. This mix of viewpoints increases innovation, as team members can approach challenges from various angles, leading to more creative and effective solutions. When people from different cultural backgrounds collaborate, they can draw from a wider range of knowledge, traditions, and strategies, often resulting in unique and unconventional thinking (Schmidt, 2023).

In healthcare settings, for example, a culturally diverse team may develop more varied and comprehensive approaches to patient care, taking into account not only medical factors but also cultural preferences, social dynamics, and different ways of coping with illness. This diversity helps identify potential gaps in care and encourages the development of new techniques or tools that can be used to improve patient outcomes.

Furthermore, culturally diverse teams are more likely to question the status quo and traditional methods, fostering an environment where creativity is encouraged. These teams tend to be more flexible and open to experimenting with new ideas, which is especially important in rapidly changing fields like healthcare, where innovation is key to improving patient care and treatment (Teixeira, 2024).

By creating an inclusive environment where diverse perspectives are welcomed and valued, organizations can tap into the full potential of their teams, leading to greater effectiveness, problem-solving ability, and overall creativity.

Reducing the Risk of Conflicts: Understanding and accepting diversity within teams plays a crucial role in reducing tensions and fostering collaboration. When

team members recognize and respect cultural differences, backgrounds, and perspectives, it creates a more harmonious working environment. This understanding helps prevent misunderstandings that may arise from miscommunication, stereotypes, or assumptions about the behaviors and values of others.

Cultural diversity in medical teams enhances creativity, fosters collaboration, and drives innovation, ultimately leading to more efficient and effective patient care.

In a culturally diverse team, there is often a greater emphasis on open communication, active listening, and empathy. These practices help team members navigate potential cultural differences and find common ground, preventing conflicts before they escalate. Recognizing that someone's behavior may stem from cultural norms rather than personal issues can reduce feelings of frustration or resentment that could otherwise arise.

Moreover, teams that actively promote inclusivity encourage individuals to express themselves without fear of judgment, helping to resolve issues before they become sources of conflict. When every team member feels respected and valued, there is less risk of negative competition or divisions within the group. As a result, collaboration improves, and the team can focus on achieving common goals rather than being distracted by internal disputes.

By creating an environment where diversity is not only accepted but celebrated, organizations can foster a more positive and productive atmosphere. This leads to the development of stronger teams, reduced stress, and more efficient workflows, ultimately resulting in better outcomes, especially in demanding fields like healthcare.

Development of Interpersonal Skills: Working in a multicultural environment offers a unique opportunity to develop key interpersonal skills such as empathy, flexibility, and effective communication, especially in difficult and complex situations. Interactions with people from diverse backgrounds, values, and beliefs challenge team members to step outside their comfort zones and understand the perspectives of others.

Empathy in a multicultural context involves the ability to put oneself in someone else's shoes, understanding their needs, emotions, and reactions within a cultural context. In such an environment, team members learn how to communicate effectively, taking into account linguistic, cultural, and social differences, which helps foster better understanding and reduce tensions.

Working in a multicultural environment enhances empathy, flexibility, and effective communication, creating stronger and more cohesive teams that are ready to face the challenges of modern healthcare.

Flexibility, a key aspect of working in a multicultural environment, refers to the ability to adapt to new and unfamiliar situations and adjust one's behavior and approach according to changing conditions and the needs of others. This flexibility allows for effective conflict resolution, finding common ground in different working styles, and efficiently managing the diverse demands of patients and colleagues.

Additionally, working in a multicultural team increases the ability to communicate effectively in challenging situations where cultural differences may lead to misunderstandings. The ability to explain intentions clearly, negotiate, and find common ground in conversations is invaluable in a team environment, especially in healthcare, where every interaction can impact treatment outcomes.

As a result, working in a diverse environment not only enriches interpersonal skills but also contributes to building more cohesive, effective, and empathetic teams that are better prepared to address the challenges of modern healthcare.

2.3. Overcoming Barriers

2.3.1. Intercultural Education

Intercultural training for healthcare staff is fundamental to effective healthcare in diverse communities.

When staff are well-prepared to work in a multicultural environment, they acquire the skills to better understand and adapt their actions to the needs of patients from various cultures. This type of education not only teaches customs, beliefs, and values, but also helps to understand how these cultural aspects influence patients' attitudes toward treatment and health. For example, in some cultures, family bonds may be very strong, which means medical decisions may require consultation with the patient's family. Other cultures may prefer traditional healing methods, which can affect the patient's openness to conventional therapies (Jongen, 2018).

Overcoming barriers in healthcare is crucial to ensuring equal access to high-quality care for all patients, regardless of their cultural, linguistic, or personal circumstances.

Such training may also address differences in verbal and non-verbal communication, which are crucial for effectively conveying medical information. Gestures, tone of voice, and even body posture may have different meanings in different cultures, and misunderstanding these cues can lead to confusion. Through intercultural education, healthcare workers learn how to avoid misunderstandings, resulting in better-quality interactions with patients (Brach & Fraserirector, 2000). Additionally, intercultural training helps healthcare staff develop greater sensitivity to differences in approaches to health and illness. Knowledge about how patients from various cultures perceive the treatment process can influence how healthcare professionals make therapeutic decisions, propose treatments, or explain medical procedures. Understanding that patients may have different expectations regarding treatment methods allows for a more personalized approach, increasing the chances of successful collaboration between the patient and healthcare staff.

As a result of intercultural education, healthcare personnel become more aware of their role not only as specialists but also as individuals who help patients feel understood and respected. This type of education leads to improved care quality,

reduced medical errors, and greater patient satisfaction because patients feel safer in interactions with staff who understand their cultural background and needs.

Healthcare systems that implement cultural diversity training and promote inclusive work processes play a crucial role in bridging the gap between medical teams and achieving equitable treatment outcomes for all patients.

To improve the quality of healthcare, healthcare organizations should provide cultural competency training for their staff to help them better understand and respect the beliefs, values, and practices of patients from diverse cultural backgrounds. These training sessions should cover topics such as cultural humility, cultural sensitivity, cultural awareness, communication skills, and strategies for overcoming cultural barriers (Saha, 2008).

2.3.2. Eliminating Biases

Awareness of one's own biases and their impact on medical decisions is a crucial element in building a fair and equal healthcare system. Everyone, regardless of their education or professional experience, holds certain unconscious preferences and biases that can influence decisions in interactions with patients. In the medical environment, these biases can lead to unequal treatment of patients, which can ultimately affect the quality of care, diagnoses, and treatment outcomes (Thompson, 2023).

Eliminating biases in healthcare ensures that every patient is treated fairly, with respect, and receives the best possible care, regardless of their background. Becoming aware of such biases is the first step toward eliminating them. When healthcare workers understand that certain behaviors, attitudes, or biases may stem from their unconscious beliefs, they are more likely to reflect on their reactions and decisions. For example, a doctor may unconsciously assume that a patient from a particular social group will not adhere to medical recommendations, which may lead to incomplete communication or less effective treatment methods. Through education on biases, medical staff can learn to recognize these unconscious beliefs and act more objectively, taking into account the needs of patients rather than relying on stereotypical assumptions (Balakrishnan,2019).

An important aspect of eliminating biases in healthcare is continuous improvement and participation in training on equality, justice, and inclusivity. These trainings help healthcare workers recognize and understand the mechanisms that lead to biases, as well as provide techniques and strategies that help mitigate their negative effects. One example of this is learning effective communication with patients from different cultures in order to minimize the risk of making unfair assumptions or judgments.

Eliminating biases in healthcare ensures that every patient is treated fairly, with respect, and receives the best possible care, regardless of their background.

Eliminating biases not only improves the quality of medical care

but also builds trust between patients and the healthcare system. Patients who feel they are treated fairly, regardless of their background, social status, race, or religion, are more open to collaborating with medical professionals. Moreover, increasing awareness of biases among healthcare staff leads to more balanced and fair medical decisions, which can contribute to better treatment outcomes and overall patient satisfaction (Thirsk, 2022).

As a result, eliminating biases in healthcare is not only an ethical issue but also a practical one, contributing to a more just, effective, and equitable medical system where all patients have equal opportunities to receive the best possible care (Horst, 2019).

2.3.3. Language Accessibility

Language accessibility is the bridge that connects patients to effective and professional care.

Language accessibility in healthcare is a key element in ensuring equal access to medical services for patients who do not speak the dominant language of the country or region. Modern societies are becoming increasingly linguistically diverse, and language barriers can significantly impact the quality of healthcare. If a patient does not fully understand medical information, instructions, or procedures, it can lead to serious treatment errors, misunderstandings regarding therapeutic recommendations, and reduced feelings of safety and comfort (For more on language accessibility, see Chapter 09).

Language accessibility is the bridge that connects patients with effective and compassionate care. A well-established approach to language accessibility helps create a more inclusive healthcare environment where every patient has equal opportunities to understand and benefit from medical services, regardless of language barriers. This approach not only improves communication but also strengthens patients' trust in the healthcare system and increases their engagement in the treatment process.

2.4. Inclusive Leadership

2.4.1. Promoting Diversity: Building Teams that Reflect the Diversity of Communities as a Key Step in Ensuring Effective and Empathetic Healthcare

Teams composed of individuals from diverse ethnic, cultural, and linguistic backgrounds, as well as those with varied life and professional experiences, are better equipped to understand the needs of patients from different environments. This representation helps break down communication barriers, build trust, and tailor care to the specific needs of various social groups.

Diversity in medical teams also fosters innovation in problem-solving. Different perspectives and approaches to situations can lead to more creative and effective decisions, which are essential in the rapidly evolving healthcare landscape. Additionally, diverse teams are better prepared for the challenges of globalization, including health issues that require knowledge of different cultures and healthcare systems.

Incorporating diversity into recruitment and training processes creates opportunities not only for individuals to bring their unique perspectives but also for organizations to become more flexible and efficient. This approach reflects a commitment to building a fair society, where every person, regardless of their background, has access to highquality healthcare.

Promoting diversity is not just an ethical obligation, but also a practical strategy that strengthens team development, improves patient experiences, and elevates the standard of healthcare, making it more accessible and effective for all.

2.4.2. Engagement: Actively Involving Staff and Patients in the Decision-Making Process

Engagement is a key element in building effective and inclusive healthcare systems. Actively involving both medical staff and patients in decision-making processes allows for a better understanding of their needs, priorities, and concerns. When healthcare workers feel their voices are heard and considered, their motivation, job satisfaction, and sense of belonging increase. Similarly, patients who actively participate in their care feel a greater sense of control over their health, which enhances their engagement in treatment and adherence to medical recommendations.

Collaboration thrives where every voice is valued.

Involving staff in decision-making processes includes regular consultations, collecting feedback, and creating spaces for open idea exchanges, regardless of position or professional experience. This approach helps organizations identify the challenges their teams face and collaboratively develop solutions that improve the efficiency and quality of care.

Engaging patients means creating environments where their opinions and preferences truly influence medical decisions. This requires healthcare profession-

als to demonstrate not only empathy and openness but also the ability to explain complex medical information in an understandable way. Including patients in discussions about their treatment plans, health goals, and therapeutic options builds trust and a sense of partnership.

Leadership brings about change most effectively when it is guided by respect, openness, and purposeful actions.

In practice, engagement can be supported through regular team meetings, advisory groups involving patients, surveys about the quality of care, or digital tools that allow patients to provide feedback in real time. The active participation of all stakeholders in decision-making processes contributes to creating more balanced and effective systems that better respond to the diverse needs of communities.

Engagement is not only a tool for improving organizational and team processes, but also a value that strengthens trust, builds relationships, and fosters a culture of mutual respect and collaboration.

2.4.3. Modeling Attitudes

Leaders play a crucial role in shaping organizational culture, which is why their approach to diversity and inclusion is so important. They should actively demonstrate openness to different perspectives, respect for differing viewpoints, and a willingness

to collaborate with people from various backgrounds.

Leading by example means that leaders not only talk about values like equality and acceptance but also practice them daily in their behavior. For instance, a leader might actively listen to team members, engage in discussions with employees from diverse backgrounds, or make decisions that reflect their needs and suggestions.

Leaders should also promote transparency and open communication, creating an environment where everyone feels comfortable expressing their opinions and concerns. This approach not only builds trust but also motivates the entire team to model these values in their everyday work.

Additionally, leaders can participate in diversity and inclusion training, demonstrating their commitment to self-improvement and a willingness to learn. Through their actions, they can inspire others to embrace change and create a work environment that reflects respect, empathy, and collaboration.

As a result, the attitudes of leaders become the driving force of the entire organization, shaping an atmosphere where diversity is seen as a strength and inclusion as the norm.

2.5. Professional Behaviors in the Context of Cultural Diversity

Professional behavior in the context of cultural diversity refers to how individuals in the workplace and other professional environments should act to respect and appreciate cultural diversity and the differences between individuals. Contemporary organizations and societies are becoming increasingly culturally diverse, which presents challenges for employees and leaders in terms of effective collaboration, communication, and managing culturally diverse teams (Araque & Weiss, 2024).

Key professional behaviors related to cultural diversity in the workplace are based on **self-reflection, flexibility, empathy, and the protection of patient rights.**

True professionalism lies in the ability to embrace diversity with respect, understanding, and flexibility, ensuring that everyone feels valued and included.

2.5.1. Self-Reflection

Self-reflection in the context of working with people from different cultures is a process of deeply contemplating one's own beliefs, values, and attitudes to better understand how these internal aspects shape our responses to others, especially during interactins with people from different cultures. Self-reflection is particularly important in healthcare, medical professions, and any field where direct interaction with patients and colleagues requires sensitivity to diversity. The diagram below illustrates the processes of cultural and adaptive development. Each stage is connected to the subsequent steps, demonstrating their interdependence (Alkhamees, 2023).

Fig. 6. The process of cultural and adaptive development

Awareness of Own Beliefs and Values

Self-reflection begins with becoming aware of one's own beliefs, which may stem from upbringing, religion, cultural traditions, education, or personal experiences. For instance, if a person comes from a culture where family plays a central role, they may have a different perspective on the priorities in the life of a patient who holds different values. Understanding how these beliefs can affect the perception of others is essential for professional behavior in interactions with patients and colleagues from diverse cultures.

Identification of Biases and Stereotypes

Each of us carries certain biases, which may result from unconsciously imitating the cultural stereotypes existing in society. Self-reflection helps identify these biases and stereotypes, enabling their elimination or minimization in interactions with others. For example, a doctor might notice that they previously assumed, perhaps wrongly, that patients from certain cultures prefer specific methods of treatment or communication. Awareness of these biases allows for the development of a more open approach to patients from various cultures.

Understanding the Impact of Own Attitudes on Interactions

Our attitudes towards others can significantly influence the quality of interactions, especially in the context of cultural differences. Self-reflection helps understand how our emotions, reactions, and behaviors shape our relationships with patients and colleagues. For example, if someone holds a negative attitude towards individuals from a particular cultural background, it may affect the way communication unfolds, hindering the development of trust. Regularly evaluating our own attitudes allows us to improve these interactions, which is especially important in professions that require empathy and understanding.

Considering the Influence of Culture on Behavior and Expectations

Self-reflection also involves analyzing how cultural differences affect the expectations and behavior of both patients and colleagues. Understanding that culture can influence the way emotions are expressed, how authority is perceived, or how time is approached provides a better foundation for creating appropriate communication strategies. For example, in some cultures, direct confrontation may be

considered rude, while in others it is seen as an expression of honesty. Awareness of these differences helps avoid misunderstandings and conflicts.

Developing Adaptive Skills

Self-reflection also helps in developing the ability to adapt to different situations and individuals. Understanding one's reactions to different behavioral styles, which may stem from varying cultural values, allows for better alignment of one's attitude with the expectations and needs of others. For example, when working with a patient from a different culture who may have a different approach to treatment, self-reflection helps adjust communication in a way that respects their beliefs while ensuring proper care.

Learning from Experience

Self-reflection is also a process of learning from experience. After every interaction with a patient or colleague, it is helpful to reflect on what went well and what could have been improved. For instance, was trust successfully built, was communication clear, or were there tensions related to cultural differences during the conversation? This type of analysis allows for continuous improvement in interpersonal skills and better preparation for similar situations in the future.

Emotion Regulation and Stress Management

Cultural differences can trigger emotions that are not always easy to control. Selfreflection helps to understand which emotions are evoked by specific situations related to intercultural interactions. This awareness allows one to learn how to better regulate their emotions, which is crucial when working with patients who may be under stress or anxiety, especially when facing cultural barriers in healthcare.

Culture as a Resource

Self-reflection also helps recognize that cultural diversity can be a valuable resource that enriches our professional practice. Understanding that each culture brings unique values, beliefs, and perspectives can help foster an empathetic approach to patients and colleagues. As a result, not only do we improve the quality of relationships, but we also enhance our ability to creatively and flexibly solve problems.

2.5.2. Flexibility

Flexibility in the context of working with patients refers to the ability to adapt one's behavior, communication style, and therapeutic approach to meet the individual needs, expectations, and cultural conditions of the patient. This is a crucial skill, especially when faced with the diversity of individuals encountered in the healthcare environment.

Recognizing the Individual Needs of the Patient

Each patient is unique, both physically and emotionally, as well as in terms of their cultural, religious, or personal beliefs. Flexibility means the ability to recognize

these differences and respond to them in a way that is tailored to the individual. For example, a patient from a different cultural background may have a different approach to treatment and prefer traditional methods over modern technologies. Similarly, a person with a history of trauma may require a specific approach characterized by more patience and empathy during conversations (Schouten, et al., 2023).

Adapting Communication Style

Flexibility also involves the ability to adjust one's communication style depending on the patient. Depending on age, education level, native language, and culture, the way information is conveyed may require modification. For example, an older patient with hearing problems may need speech to be clear and slow, while a younger patient with better access to modern media may prefer a more dynamic and concise form of communication. Additionally, in a cultural context, differences in verbal and nonverbal communication can significantly impact the effectiveness of interactions. In some cultures, directly asking questions may be considered impolite, while in others, it is seen as normal.

Adapting Therapeutic Approach

Flexibility also refers to the ability to adjust the treatment approach based on the patient's preferences. For example, a patient who adheres to a specific religion may prefer therapies aligned with their faith, incorporating prayers, meditation, or other spiritual practices into the therapeutic process. On the other hand, a patient with medical experience may be more open to modern treatment methods but might require detailed explanations about the process. In such cases, a flexible therapeutic approach may involve integrating traditional methods with modern ones, respecting the patient's beliefs while ensuring effective care.

Empathy and Active Listening

Flexibility in communication is also tied to empathy and the ability to actively listen. When a patient feels understood and respected, they are more likely to openly discuss their health status, concerns, and needs. Flexibility means that healthcare workers can adjust their responses to the patient's emotions and level of comfort. For example, if a patient expresses fear about a treatment, flexibility involves adjusting the tone of voice, body language, and the way procedures are explained to ensure a sense of safety and comfort.

Understanding the Impact of Culture on Patient Expectations

Flexibility in communication also means recognizing that cultural differences can influence a patient's expectations regarding treatment, communication, and relationships with healthcare providers. For instance, in some cultures, there is greater respect for hierarchy, meaning the patient may expect the doctor to make all decisions without involving them in the details. In other cultures, patients may prefer a more collaborative approach, where they are fully engaged in the decision-making process.

Flexibility in Responding to Changes in the Patient's Health Condition

Flexibility is not only the ability to adapt to an initial approach with a patient, but also the capacity to respond to changing circumstances during treatment. Changes in a patient's health, their reactions to treatment, or developing emotional needs require quick adaptation. Flexibility means adjusting the treatment plan to meet the unique needs of the patient.

Maintaining Professionalism Despite Changing Circumstances

While it is essential to adapt to the patient, it is equally important to maintain professionalism and protect personal boundaries. Flexibility does not mean abandoning ethical or professional standards but rather the ability to adjust an approach in a way that remains consistent with the requirements of the profession and the patient's wellbeing. For example, if a patient attempts to cross professional boundaries (e.g., requesting unethical actions), flexibility involves gently but firmly reminding them of the professional limits.

Creative Problem-Solving

Working with patients from diverse cultural backgrounds or with varying needs also requires the ability to think creatively to solve problems. Sometimes a patient may have unusual needs that cannot easily be met with standard procedures. In such cases, flexibility allows for finding new, appropriate solutions that are both effective and respectful of the patient's individual requirements.

2.5.3. Empathy

Empathy is a key skill in working with patients, especially in the context of cultural diversity. It involves the ability to understand and share the feelings of a patient, regardless of their cultural, religious, social, or emotional background. In healthcare, empathy facilitates more effective communication, builds trust, and allows for tailoring care to the individual needs of the patient (Gonzalez-Tapia, 2023).

Understanding the Patient's Emotions

Empathy begins with the ability to recognize and understand the patient's emotions, even when they are expressed in a way that differs from what we are accustomed to. The patient may experience fear, uncertainty, pain, or frustration, and understanding these feelings is crucial for providing appropriate care. Regardless of the patient's cultural background, their emotions deserve respect and understanding. Empathy enables healthcare professionals to adjust their communication to make the patient feel heard and understood.

Professionalism involves sensitivity, recognizing differences, and providing care tailored to the needs of each individual.

Active Listening

Active listening is the foundation of empathy. It involves fully focusing on the patient, understanding their words, and also noticing non-verbal cues such as facial expressions, body posture, and tone of voice. Active listening allows for a better understanding of the patient and their needs, which is especially important in the context of cultural differences. Often, what the patient says does not fully reflect the extent of their emotions, so it is important to listen "between the lines" and notice what remains unspoken.

Understanding Different Cultural Perspectives

Empathy is not only about sharing the patient's feelings, but also understanding that they may view the world differently due to their culture, religion, or traditions. For example, in some cultures, there is great respect for the authority of the doctor, which might make the patient hesitant to express concerns or doubts, even if they feel them. In other cultures, patients may be more open to discussing their health issues. Empathy requires understanding these differences and adjusting communication so that the patient feels comfortable and has the opportunity to freely express their needs.

Compassion Without Judgement

Empathy also involves the ability to avoid judgment. Regardless of how the patient views their situation or the decisions they make about their health, it is important to show understanding and compassion. The patient may make decisions that seem to contradict medical advice. Without empathy, it is easy to judge them. Understanding that the patient's decisions may stem from their fears, beliefs, life experiences, or cultural background helps to create an environment where the patient feels supported rather than criticized.

Adjusting to Individual Needs

Empathy requires healthcare workers to adjust their approach to the individual needs of the patient, taking into account not only their health condition but also the emotional and cultural aspects of their life. For some patients, a detailed explanation of the treatment process may be helpful, while for others, it may be most important to ensure that their spiritual or cultural beliefs are respected. Empathy allows healthcare providers to recognize these subtle differences and adapt their approach accordingly.

Building Trust and Relationships

Empathy is the foundation for building trust between the patient and healthcare providers. A patient who feels understood and respected is more likely to cooperate, which is crucial for the treatment process. Trust, in turn, improves communication, leads to better understanding of the patient's needs, more effective treatment, and greater satisfaction with healthcare services.

Coping with Difficult Situations

Empathy is also invaluable in handling emotionally difficult situations. For patients in the terminal stages of illness, those with serious health issues, or those experiencing crises, empathy helps provide support, a sense of security, and comfort. Understanding the patient's emotions in such moments is crucial to help them navigate through challenging experiences, offering not only physical support but also emotional solace.

Strengthening the Patient's Sense of Dignity

Empathy helps maintain the patient's dignity, especially in situations that may be difficult or humiliating for them, such as medical examinations or procedures. Showing understanding and compassion makes the patient feel more comfortable, which is essential for their well-being and how they perceive the quality of the care they are receiving.

Empathy in patient care is the ability to immerse oneself in their situation and understand their perspective, regardless of cultural differences. This includes active listening, avoiding judgment, understanding the patient's emotions and cultural background, and adjusting the approach to meet individual needs. Through empathy, the patient feels respected, understood, and supported, significantly improving the quality of care and strengthening the relationship between the patient and healthcare professionals (Riess, 2014).

2.5.4. Patient Rights Advocacy

Patient rights advocacy in healthcare refers to actively promoting equality and justice in access to medical care, particularly through the elimination of inequalities and support for marginalized groups. Advocacy is not limited to fighting for patient rights; it also includes efforts to reform systems that may hinder equal and fair access to healthcare. Actions within advocacy can encompass a broad range of interventions, from individual-level efforts to systemic changes (Sundler, 2020).

Promoting Equal Access to Healthcare

Patient rights advocacy asserts that every individual, regardless of their background, social status, or economic situation, deserves equal access to high-quality healthcare. Many people, particularly those from marginalized groups (e.g., individuals from lowincome families, ethnic minorities, people with disabilities), face barriers to accessing healthcare, such as lack of health insurance, communication difficulties with healthcare providers, or limited access to specialized services. Patient advocacy aims to remove these obstacles and fight for ensuring that every patient has an equal opportunity to receive care tailored to their individual needs.

Eliminating Social and Economic Inequalities

Social and economic inequalities have a direct impact on the quality and accessibility of healthcare. Advocacy focuses on identifying and eliminating these inequalities, which may influence patients' health decisions or restrict their access

to appropriate care. Individuals living in poverty, the elderly, ethnic minorities, and LGBTQ+ individuals may experience discrimination in healthcare, leading to worse health outcomes. Actions such as lobbying for health policies that address these inequalities aim to create a fairer healthcare system that takes the needs of every patient into account.

Empathy in Care is Understanding Beyond Differences.

Support for Marginalized Groups

Advocacy is particularly important for social groups that may not have a voice in traditional decision-making processes. Groups such as ethnic minorities, people with disabilities, the elderly, LGBTQ+ individuals, and those living with HIV/AIDS often face additional challenges in accessing healthcare. Representatives work on behalf of these individuals to ensure they have access to appropriate medical services and raise awareness of their specific health needs. Supporting marginalized groups involves educating both society and healthcare professionals about these challenges and promoting equality in all aspects of healthcare.

Education and Social Awareness

Patient rights advocacy is not only about working within the healthcare system but also about educating society and institutions on issues related to inequalities in healthcare access. Collaborating with non-governmental organizations, conducting public campaigns, creating reports and studies on healthcare inequalities, and promoting public policies that increase the availability and quality of healthcare services for marginalized groups—all contribute to advocacy efforts. Raising social awareness about healthcare inequalities is crucial in mobilizing change at the local, national, and global levels.

Collaboration with Legislators and Shaping Health Policy

Advocacy in healthcare also involves efforts to create public policies that promote equality and justice in access to healthcare. This includes not only local-level actions but also influencing legislators and politicians to implement changes in health regulations that are more just and equitable. This can involve lobbying for changes in health insurance policies, access to medications, and reforms in healthcare systems that address inequalities arising from various social and economic factors.

Actions at the Individual Level

Advocacy is not limited to systemic or political actions but can also include efforts at the individual level. In the context of healthcare, this may involve helping patients navigate the healthcare system, representing their interests in interactions with doctors or medical facilities, and providing support throughout the treatment process. Often, patients from marginalized groups may not know how to effectively use the healthcare system, and the role of the advocate is to provide information, emotional support, and assistance in resolving potential issues.

Challenges in Patient Advocacy

Advocacy can face many challenges, including resistance from institutions accustomed to functioning in ways that do not prioritize equality and justice. Additionally, changes in the healthcare system require time, resources, and collaboration from various stakeholders. Despite these challenges, advocacy efforts are critical in striving for a more just, equal, and accessible healthcare system.

Supporting equality within the healthcare system plays a crucial role, as every individual deserves to have their voice heard, and every person is entitled to equal access to care.

Patient advocacy in healthcare is the active pursuit of promoting equality, justice, and eliminating inequalities in access to medical care. It involves both systemic and individual actions aimed at supporting marginalized groups, educating society, collaborating with decision-makers, and creating health policies that promote equality. The goal is to create a just healthcare system that ensures every patient has access to appropriate healthcare services, regardless of their social or cultural background.

References

Alkhamees, M., & Alasqah, I. (2023). Patient-physician communication in intercultural settings: An integrative review. *Heliyon*, 9(12), e22667. https://doi.org/10.1016/j.heliyon.2023.e22667

Araque, J. C., & Weiss, E. L. (n.d.). *Cultural proficiency and diversity considerations in the workplace*. In Leadership with Impact (pp. 63–286).

Balakrishnan, K., & Arjmand, E. M. (2019). The impact of cognitive and implicit bias on patient safety and quality. *Otolaryngologic Clinics of North America*, 52(1), 35–46.

Borowczyk, M., Stalmach-Przygoda, A., Doroszewska, A., Libura, M., Chojnacka-Kuraś, M., Małecki, Ł., Kowalski, Z., & Jankowska, A. K. (2023). Developing an effective and comprehensive communication curriculum for undergraduate medical education in Poland – The review and recommendations. *BMC Medical Education*, 23(1), 645. https://doi.org/10.1186/s12909-023-04533-5

Brach, C., & Fraserirector, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review*, 57(Suppl 1), 181–217.

Culyer, T. (1995). Need: The idea won't do – but we still need it. *Social Science & Medicine*, 40(6), 727–730.

Ersek, M., Smith, D., Griffin, H., Carpenter, J. G., Feder, S. L., Shreve, S. T., et al. (2020). End-of-life care in the time of COVID-19: Communication matters more than ever. *Journal of Pain and Symptom Management*, 62, 213–222.

Fatima Cody Stanford. (2020). The importance of diversity and inclusion in the healthcare workforce. *Journal of the National Medical Association*, 112(3), 247–249.

Gebhardt, C., Mehnert-Theuerkauf, A., Hartung, T., Zimmermann, A., Glaesmer, H., & Götze, H. (2021). COMSKIL: A communication skills training program for medical students. GMS *Journal of Medical Education*, 38, Doc83.

Gill, G. K., McNally, M. J., & Berman, V. (2018). Effective diversity, equity, and inclusion practices. *Healthcare Management Forum*, 31(5), 196–199. https://doi.org/10.1177/0840470418773785

Gonzalez-Tapia, G., & Lazzaro-Salazar. (2023). Medical empathy in the physician-patient relationship: A review from a cultural perspective. *Revista Médica de Chile*, 151(9), 1233–1240. https://doi.org/10.4067/s0034-98872023000901233.

Horst, A., Schwartz, B. D., Fisher, J. A., Michels, N., & Van Winkle, L. J. (2019). Selecting and performing service-learning in a team-based learning format fosters dissonance, reflective capacity, self-examination, bias mitigation, and compassionate behavior in prospective medical students. *International Journal of Environmental Research and Public Health*, 16(20), 3926.

Jongen, C., McCalman, J., & Bainbridge, R. (2018). Health workforce cultural competency interventions: A systematic scoping review. *BMC Health Services Research*, 18, Article 232.

Karliner, L. S., Jacobs, E. A., Chen, A. H., & Mutha, S. (2007). Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Services Research*, 42, 727–754. https://doi.org/10.1111/j.1475-6773.2006.00629.x

Kienle, R., Freytag, J., Lück, S., Eberz, P., Langenbeck, S., Sehy, V., et al. (2021). Communication skills training in undergraduate medical education at Charité – Universitätsmedizin Berlin. *GMS Journal of Medical Education*, 38, Doc56.

Nair, L., & Adetayo, O. A. (2019). Cultural competence and ethnic diversity in healthcare. *Plastic and Reconstructive Surgery – Global Open*, 7, e2219. https://doi.org/10.1097/GOX.0000000000002219

Puch, E. A., Nowak-Jaroszyk, M., & Swora-Cwynar, E. (2020). Medical error in theory and practice – A review of the most important issues. *Medycyna Pracy*, 71(5), 613–630.

Rider, E. A., Hinrichs, M. M., & Lown, B. A. (2006). A model for communication skills assessment across the undergraduate curriculum. *Medical Teacher*, 28, e127–e134.

Riess, H., & Kraft-Todd. (2014). E.M.P.A.T.H.Y.: A tool to enhance nonverbal communication between clinicians and their patients. *Academic Medicine*, 89(8), 1108–1112. https://doi.org/10.1097/ACM.0000000000000287

Rozlog, L. A., Kiecolt-Glaser, J. K., Marucha, P. T., Sheridan, J. F., & Glaser, R. (1999). Stress and immunity: Implications for viral disease and wound healing. *Journal of Periodontology*, 70(7), 786–792. https://doi.org/10.1902/jop.1999.70.7.786

Saha, S., Beach, M. C., & Cooper, L. A. (2008). Patient centeredness, cultural competence, and healthcare quality. *Journal of the National Medical Association*, 100(11), 1275–1285.

Schmidt, M., Steigenberger, N., Berndtzon, M., & Uman, T. (2023). Cultural diversity in health care teams: A systematic integrative review and research agenda. *Health Care Management Review*, 48(4).

Schouten, B. C., Manthey, L., & Scarvaglieri, C. (2023). Teaching intercultural communication skills in healthcare to improve care for culturally and linguistically diverse patients. *Patient education and counseling*, 115, 107890. https://doi.org/10.1016/j.pec.2023.107890

Sirois, F. M., & Hirsch, J. K. (2018). Self-compassion and adherence in five medical samples: *The role of stress. Mindfulness*, 10(1), 46–54.

Sundler, A. J., Darcy, L., Raberus, A., & Holmström, I. K. (2020). Unmet health-care needs and human rights – A qualitative analysis of patients' complaints in light of the right to health and health care. *Health Expectations*, 23(3), 614–621.

Final Reflection: Relevance to Cultural Competence and the EMPOWER Model

by Małgorzata Szkup

The chapter „Diversity and Inclusion in Healthcare" directly aligns with the assumptions of the EMPOWER model, serving as its practical and conceptual extension. The discussed issues—such as the importance of cultural diversity, the need for inclusive leadership, the development of interpersonal skills, and the elimination of barriers in access to healthcare—reflect the core pillars of the model: **Effectiveness, Multiculturalism, Professionalism, Wellness, and Education Resources.**

The content of this chapter particularly supports the development of **reflective cultural** competencies, which are the foundation of the EMPOWER model. Emphasis on self-awareness, empathy, flexibility, and self-reflection in healthcare teams echoes the concept of **cultural humility** —a central component of EMPOWER. The chapter stresses that true understanding of a patient requires not only knowledge but also a willingness to learn from them, which is a guiding principle of the model.

Moreover, the chapter promotes **strengthening the role of patients**, especially in the context of building trust-based and culturally sensitive relationships. The principle of active patient involvement, strongly emphasized in the EMPOWER model, is clearly reflected in the described strategies for tailoring care to the cultural and linguistic needs of healthcare users.

The chapter also addresses the importance of **professional wellness** among healthcare providers, demonstrating that working in a culturally diverse environment requires emotional, educational, and organizational support. The focus on developing soft skills, such as emotional regulation and stress management, corresponds with the **Wellness** component of the EMPOWER model, which advocates for a healthy learning and work environment.

In conclusion, this chapter provides a solid theoretical and practical foundation for implementing the EMPOWER model in healthcare education and practice. It demonstrates that effective healthcare in a culturally diverse society requires not only knowledge of differences but also an **attitude of openness, humility, and continuous development**, all of which the EMPOWER model actively fosters.

Multi Culti Med

Chapter 3

Globalization and Multiculturalism

in Medical Education and Therapeutic Teams

OLHA FEDORTSIV, EMILIA BURBELA, VOLODYMYR DZHYVAK

Ivan Horbachevsky Ternopil National Medical University of the Ministry of Health of Ukraine (Ukraine)

> **Elimination of inequalities in health care both within and across borders between countries is a basic principle of medical professionalism.**
>
> "Medical Professionalism in the New Millennium: A Medical Charter"
> The American Board of Internal Medicine, the American College of Physicians, the American Society of Internal Medicine, the European Federation of Internal Medicine and the Canadian Medical Association, 2002

3.1. Introduction

Globalization is changing health and healthcare. Increasing global migration and forced displacement due to wars, conflicts, crises, natural disasters increase the risks of spreading various diseases and highlights the interconnections in health and medicine between continents (Drain, et al., 2007)

Globalization in education leads to the expansion of academic mobility, unification of curricula and teaching methods, rapid development of distance learning, use of new forms in education, which contributes to the integration of medical science into a scientific global space (Dvornik et al., 2022).

As Knight (2020) notes, the landscape of internationalization has changed significantly in recent years, presenting both positive and negative implications for higher education institutions around the world. This evolution is part of a broader shift towards globalization, in which institutions are increasingly focused on preparing students for an interconnected world.

In recent years, there has been a significant increase in the demand for training in global health and multiculturalism among medical and health science students. Changes in the medical professions and beyond require the expansion of global health training for students to enable them to fulfil their professional and societal responsibilities more effectively (Izadnegahdar, et al., 2008) For universities, internationalization involves adopting a more welcoming attitude, creating increased opportunities for international students and faculty,introducting various initiatives, promoting of international partnerships and exchange programes, offering opportunities to learn languages and cultures, and fostering diversity and inclusiveness within university life.

Cultural diversity is “the existence of diverse cultural or ethnic groups in a society”. In other words, this phenomenon refers to a population where numerous differences between cultures are represented. Types of diversity in the workplace include, among others, race, ethnicity, age, ability, language, nationality, socioeconomic status, gender, religion, or sexual orientation. Given the political and world history, it is important to understand what cultural diversity means in the workplace and in the team, especially if the goal of the team is to protect human life and health.

Culture is something that shapes a person, influences their behavior, beliefs and defines their identity. Cultural diversity in the workplace is the inclusion of employees of different backgrounds, races, genders, sexual orientations, and political views. The term "cultural diversity" encourages an environment of inclusion in which people of different cultures and backgrounds come together to work as a team.

Aims

Through this chapter students will enhance their attitudes, knowledge and skills in:

- **Exploring globalization:** Analyze how globalization influences healthcare practices and policies across different cultural contexts, focusing on concepts such as ethnocentrism, acculturation, assimilation, and integration.
- **Defining Key Concepts:** Clarify terms like globalization, ethnocentrism, acculturation, assimilation and integration.
- **Identifying Multiculturalism:** Recognize the importance of multiculturalism in fostering inclusive medical education and effective therapeutic teams.
- **Emphasizing Diversity:** Highlight the significance of diverse perspectives in enhancing patient care and improving outcomes within healthcare settings.

Learning Outcomes

By the end of this chapter, readers will be able to:

- **Describe how globalization** affects health systems and practices in different cultural settings.
- **Define key terms:** Define "multiculturalism" and its importance for creating an inclusive medical education environment, "globalization", "cosmopolitanism", "ethnocentrism", "acculturation", "multiculturalism policy in the workplace".
- **Identify multiculturalism:** Understand how an awareness of diverse cultural backgrounds improves teamwork and collaboration in health care settings.
- Illustrate the role of **diverse perspectives** in improving patient care and outcomes in clinical practice.
- Discuss the benefits of **cultural competence** and global health education in shaping the future behavior and competence of healthcare professionals.

Relevant Definitions and Terms

Globalization: Globalization in healthcare refers to the increasing interconnectedness of health systems, practices, and policies across the world. This includes the exchange of medical knowledge, technology, and resources, as well as the movement of healthcare professionals and patients across borders. Understanding globalization is essential for medical and health science students, as it impacts public health, access to medical care, and the spread of diseases (Beaglehole & Bonita, 2010).

Cosmopolitanism: Cosmopolitanism in a medical context emphasizes the importance of treating all patients with respect and dignity, recognizing their diverse backgrounds and cultural identities. Medical professionals should adopt a cosmopolitan approach to healthcare, which involves being open to different health beliefs and practices and understanding that cultural competence is vital for effective patient care and treatment outcomes (Hagger & Orbell, 2003).

Ethnocentrism: Ethnocentrism refers to the practice of evaluating other cultures using the standards of one's own culture, which can lead to biases in healthcare delivery. For medical and health science students, understanding ethnocentrism is crucial for recognizing potential prejudices that may affect patient interactions, adherence to treatment, and overall health outcomes. It underscores the importance of cultural humility and respect in medical practice (Henrickson, 2006).

Acculturation: Acculturation in healthcare refers to how patients from different cultural backgrounds adapt to new healthcare systems and practices. Students should be aware of this process, as it can influence patient behaviors, beliefs about illness, and attitudes toward treatment. Understanding a patient's acculturation experience can help healthcare providers offer more personalized and effective care (Rojas & Smith, 2009).

Multiculturalism Policy in the Workplace: Multiculturalism policy in the healthcare workplace involves creating an inclusive environment that values diversity among healthcare providers and patients. For medical students, understanding these policies is important for fostering collaboration and communication in diverse teams, enhancing patient-centered care, and addressing health disparities among various cultural groups (Kuehn, 2017).

Multiculturalism: Multiculturalism in healthcare recognizes and values the presence of diverse cultural groups within the patient population. For students, embracing multiculturalism means being aware of cultural variations in health beliefs, practices, and preferences. This perspective is crucial for providing competent care that respects individual needs and improves health outcomes in a diverse society (Bhui & Dinos, 2015).

3.2. What the Research Says

3.2.1. Globalization

The concept of global literacy includes critical thinking about global issues, cultural sensitivity, cooperative behavior and intercultural respect (Bulut & Öksüzoğlu, 2021).

Global literacy includes four main dimensions (Zhang, Hsu & Wang, 2010):

1. awareness of diverse cultures,
2. adoption of global citizenship,
3. Recognition of the interconnectedness of nations
4. confidence in using new skills to succeed in the „global village".

The Global Village is a sociological and philosophical term that refers to the fact that modern humanity lives in close interaction thanks to technological advances that reduce geographical and cultural barriers. The concept emphasizes how globalization and communication technologies create a sense of community among people from different parts of the world.

Two main foundations are important for defining a global citizen:

- cosmopolitanism - as an acceptance and understanding of the culture of others
- ethnocentrism - as a basis for preserving one's own ethnic and cultural identity.

Cosmopolitanism refers to the ideology that all human beings, regardless of their national, ethnic, or cultural affiliations, belong to a single global community. It advocates for the idea that individuals have moral obligations to others beyond their local or national ties, emphasizing universal values and mutual respect among diverse cultures. For official documentation, organizations such as the United Nations often promote principles aligned with cosmopolitanism, particularly in relation to human rights, global cooperation, and sustainable development. In documents connected to global citizenship education, for instance, cosmopolitanism is portrayed as fostering a sense of belonging to a larger human family and promoting the idea of interconnectedness among people worldwide (Pogge, 2006).

Contemporary medical and health science students face the challenge of understanding and recognizing the complexity and uniqueness of individuals' experiences. This is the basis of the concept of cosmopolitanism, which, together with humanism, concern for others, the need for intercultural appreciation and sensitivity, should be integral features of professions that are closely related to the care and treatment of people.

3.2.2. Globalisation in medical education

Globalisation in education is leading to increased academic mobility, unification of curricula and teaching methods, rapid development of distance learning; understanding of the need to use new forms of education is growing. Exchange programes for students are well known: Erasmus (EU), DAAD (Germany), Global UGRAD (USA). Every year, more and more students are willing to use these opportunities. This is facilitated by mutual recognition of diplomas, the formation of a network European university, obtaining a second higher education, the creation of a European center for education development, and unlimited state borders of the higher education institution.

Flexibility, adaptability, modularity, cost-effectiveness, consumer orientation, and reliance on advanced communication and information technologies are becoming characteristic features of the modern educational process. This has created the conditions for the development of the global educational space, acculturation, export and import of education, and the unification of the world's intellectual, creative, information, scientific and pedagogical potentials.

Although medicine is inextricably linked to the phenomenon of globalization, very few medical and health science students have experience in global health and sufficient knowledge of cultural studies. This is often due to high costs, lack of motivation and interest of teachers. It can also be linked to curricula that either do not include these components or require students to develop their own capabilities.

To communicate between students, as well as teachers and healthcare professionals, there are various platforms, chats, groups where interesting clinical cases, tasks or tests are discussed, peculiarities of care depending on the circumstances, opportunities for international internships, involvement in grant programes, etc. It's worth trying to join them.

The modern world is intensively globalizing, and the deepening of intercultural communications contributes to the transformation of worldviews and generates innovative searches in each culture. The interaction of cultures generates the need to rethink the importance of intercultural contacts and one's own cultural identity, which is based on the idea of intercultural tolerance, adequate perception of cultural differences, which are, in such circumstances, necessary prerequisites for effective relations between cultures and mutual understanding between their speakers (Kovtun & Harmash, 2020).

3.2.3. Ethnocentrism

According to Dutton, et al. (2016), there are two types of ethnocentrism: positive and negative. Positive ethnocentrism refers to pride in one's ethnic group or nation and a willingness to sacrifice for it, while negative ethnocentrism implies unreasonable prejudice and hostility towards other ethnic groups.

While some degree of ethnocentrism is widespread, it can vary across racial and ethnic groups. Also, the intensity, or even polarity, of ethnocentrism can fluctuate and change, depending on the surrounding circumstances, changes in social circle, or other factors. For example, studies by Turkish researchers (Karadas, et al. 2023, Köse, İpek & Çopur, 2024) analysed the level of ethnocentrism and xenophobia among nurses who worked with refugees, as their number has increased dramatically in Turkey over the past few years. It was found that the level of ethnocentrism was below average and xenophobia was above average, and there was a direct proportional relationship - as the level of ethnocentrism increased, so did the level of xenophobia. This study demonstrates current trends and problems in the provision of healthcare services in certain societies.

Ethnocentrism (Greek: ethnos – group, tribe, people; Latin: centrum – focus, centre) is the ability of individuals, social groups and communities (as carriers of ethnic identity) to perceive and evaluate life phenomena through the prism of traditions and values of their own ethnic community, which acts as a certain general standard or optimum.

A study conducted by Japanese researchers showed that people with a higher level of ethnocentrism do not always reject other cultures, have limited global literacy, or have no desire to be global citizens. In contrast, pride and identification with Japanese culture and values are positively related to global literacy. According to social identity theory, ethnocentrism is in most cases seen primarily as an in-group positivity independent of external groups (Zhang & Takahashi, 2024), which means that ethnic identity should not simply be seen as a rejection of foreign groups or foreign cultures.

> *„War pushes for changes and adaptations, and vice versa, changes in society affect the war", „war is a kind of elixir for society, which makes it stronger and manifests it noble parties"*
>
> *- MacMillan, M. (2020). War: How conflict shaped us [First U.S. edition]. New York, Random House.*

Ethnic identity becomes even more pronounced in times of conflict. Using data from thirty-six African countries (Bizumic, Monaghan & Priest, 2021) examined the relationship between ethnic conflict and various indicators of social cohesion and found a positive correlation. This finding is understood to be the result of the ethnocentric dynamics generated by the conflict: war increases ethnic iden-

tification and pro-social behaviour. Similar conclusions have also been reached by Ukrainian historians analysing the wars that took place on the territory of Ukraine. The war qualitatively accelerated the processes of national self-discovery. It prompted a clear choice of "friend or foe". The result was a deepening of national self-reflection. The war became a means of rethinking, finding, and constructing one's own identity (Borchuk & Kostyuchok, 2024). Despite the fact that ethnocentrism is often seen as an obstacle to interethnic and intercultural interaction, it serves to maintain and preserve ethnic selfidentity, integrity and specificity (Ustymenko, 2018).

3.3. Multiculturalism and Diversity in Therapeutic Teams

"Of all forms of inequality, health injustice is the most shocking and inhumane"

- Dr Martin Luther King

Cultural diversity plays a key role in teams, bringing equality and a wealth of diverse perspectives. Numerous studies conducted in highly developed countries emphasize its positive impact and the importance of inclusivity for business and economic success(Jaganya, Janani & Durgalakshm, 2024).

Types of workplace diversity:

- **gender** (women make up a larger percentage of the workforce than ever before),
- **race and ethnicity** (developing ethnic and racial identity leads to improved cultural diversity),
- **transgender community** (a complex range of people in terms of backgrounds, experiences and challenges, requiring special attention in terms of employer strategy),
- **age** (both younger and older employees may experience bias; providing training for all ages and mentoring programmes can help to ensure that the workplace is diverse and inclusive),
- **employees with disabilities** (disability can encompass many differences and should be addressed by combating negative perceptions of people with mental or physical disabilities),
- **mental health** (focusing on mental health, along with providing workplace wellness, will help to combat a variety of mental health issues),
- **neurodiversity** (recognising and providing a favourable environment for people with neurological differences helps teams to recognise differences and preferences in the selection of the type of work),

Multiculturalism in the workplace brings numerous benefits, such as increased creativity, better teamwork and increased productivity.

- **thinking style** (each person has a different thinking style, which can increase creativity if the person and his/her role in the team are well matched and vice versa, it can cause stress if it is not matched correctly).

A multicultural team is a team whose members come from different countries, different ethnicities and cultures, and speak different languages. Each member of such a team should demonstrate cultural sensitivity. It is also important to show respect for diversity and take into account different cultural customs and requirements. Cultural diversity in the workplace allows for teams that bring together different perspectives and talents, increasing innovation and contributing to higher efficiency and productivity. Companies with leadership teams in the top 25% of racial and ethnic diversity have been shown to be 33% more likely to outperform their peers in terms of profitability (Hunt, et al., 2018).

Examples of companies that have successfully implemented multicultural policies include:

- Google - a company that actively supports cultural diversity through training and development programmes aimed at attracting employees from different cultures
- Microsoft is a company that provides training in intercultural competence and creates an inclusive work environment where different cultural values are respected.

A diverse team means more innovation, more informed decisions and better results, which adds value to all stakeholders. An inclusive culture means listening to all employees and respecting their work. It also helps to maintain a satisfactory work environment that ensures personal and professional success (Afridah & Lubis, 2024).

A multicultural workplace should focus on bringing together culturally diverse needs that are directly related to work, as well as broader opportunities and habits. Consideration should be given to the nutritional and food quality of canteens for employees of different cultures, and the need for a prayer or meditation room in accordance with cultural needs.

Cultural diversity helps to develop and maximise skills and talents (Thomas, 2024). The diversity of ideas and experiences allows you to learn from colleagues of other cultures, increase your problem-solving ability and increase productivity. In an environment where all voices are heard, this spirit of innovation and encouragement to contribute contributes to workplace success. Cultural diversity increases the creativity of the workforce. By listening to the opinions and ways of thinking of each employee, a company or team will have different ways of solving its tasks. In a collective, a team that actively encourages diversity in the workplace, more perspectives are discussed and more solutions are offered, which can encourage people to work at their best.

Training in cultural competence and humility can be very important in overcoming cultural problems in a team. This is a good way to allow team members to get to know each other and learn about different cultural beliefs and practices.

This training should cover the following issues:

- how to minimise cultural barriers;
- how to avoid stereotypes and prejudices;
- how to value the culture of your own and others.
- how to improve your social skills;
- how to become a better listener;
- how to focus on commonalities rather than differences.

This training should be relevant to the needs of the team, teaching them to understand people's behaviour and reactions in the work environment, especially when there are clear differences.

Multiculturalism Policy in the Workplace

A Diversity, Equality, Inclusion and Belonging policy should be thoughtful and focused on promoting an inclusive culture, which should be included in what is known as a Code of Conduct, which outlines ethical standards and expectations for all employees, faculty, students, etc., to ensure integrity and compliance.

A multiculturalism policy is about creating an environment where all team members have a strong sense of belonging, including race, creed, colour, religion, gender, age, ancestry, marital status, nationality, sexual orientation, gender identity, ethnicity, genetics, disability, impairment, veteran status or any other status protected by regulation or law, applying standards of equal treatment in decisions about employment, training, compensation, etc (Karatekin, et al., 2019) It is the creation of a work environment where everyone is treated with dignity. Such an environment is free from violence or harassment, intimidation, including verbal or physical threats, and any other acts of aggression or violence. It is the creation of a safe, hygienic and healthy working environment for the safety and health of all employees or team members. Each person to whom this Policy applies is responsible for compliance with the provisions of this Policy.

References

ABIM Foundation, American Board of Internal Medicine, ACP-ASIM Foundation, American College of Physicians-American Society of Internal Medicine, & European Federation of Internal Medicine. (2002). Medical professionalism in the new millennium: A physician charter. Annals of Internal Medicine, 136(3), 243–246. https://www.annals.org/cgi/content/full/136/3/243

Afridah, & Lubis, M. (2024). The role of communication and employee engagement in promoting inclusion in the workplace: A case study in the creative industry. Feedback International Journal of Communication, 1, 1–15. https://doi.org/10.62569/fijc.v1i1.8

Anisman, H., Doubad, D., Asokumar, A., & Matheson, K. (2024). Psychosocial and neurobiological aspects of the worldwide refugee crisis: From vulnerability to resilience. Neuroscience & Biobehavioral Reviews, 165, 105859. https://doi.org/10.1016/j.neubiorev.2024.105859

Beaglehole, R., & Bonita, R. (2010). Global public health: A new era. The Lancet, 375(9717), 1560–1561.

Bhui, K., & Dinos, S. (2015). Cultural competence in mental health: A global perspective. International Review of Psychiatry, 27(1), 60–69.

Bizumic, B., Monaghan, C., & Priest, P. (2021). The return of ethnocentrism. Political Psychology, 42, 29–73.

Borchuk, S., & Kostyuchok, P. (2024). Catalysts of the national identity of Ukrainians in the Carpathian region during the First World War. Eminak, 3(47), 147–165.

Bulut, B., & Öksüzoğlu, M. K. (2021). Global literacy in education. In E. Koçoğlu (Ed.), Literacy skills in education-III (pp. 321–337). Pegem Academy. https://doi.org/10.14527/9786257582018.

Choy, B., Arunachalam, K., Gupta, S., Taylor, M., & Lee, A. (2021). Systematic review: Acculturation strategies and their impact on the mental health of migrant populations. Public Health in Practice, 2, 100069. https://doi.org/10.1016/j.puhip.2020.100069

Dutton, E., Madison, G., & Lynn, R. (2016). Demographic, economic, and genetic factors related to national differences in ethnocentric attitudes. Personality and Individual Differences, 101, 137–143. https://doi.org/10.1016/j.paid.2016.05.049

Drain, P. K., Primack, A., Hunt, D., Fawzi, W., Holmes, K., & Gardner, P. (2007). Global health in medical education: A call for more training and opportunities. Academic Medicine, 82(3), 226–230.

Dvornik, V. M., Kuz, H. M., Yeris, L. B., Teslenko, O. I., & Kuz, V. S. (2022). Trends in modern medical education. Poltava State Medical University.

Hagger, M. S., & Orbell, S. (2003). A psychological model of health behavior. Social Science & Medicine, 57(1), 123–132.

Henrickson, M. (2006). The ethnocentric bias: Implications for global health. In K. C. R. Schenck (Ed.), Cultural competence in health care: A practical guide to improving patient satisfaction and quality of care (pp. 139–152).

Hunt, V., Prince, S., Dixon-Fyle, S., & Yee, L. (2018). Delivering through diversity. McKinsey & Company. https://www.mckinsey.com/capabilities/people-and-organizational-performance/ourinsights/delivering-through-diversity

Izadnegahdar, R., Correia, S., Ohata, B., Kittler, A., Kuile, S., Vaillancourt, S., Saba, N., & Brewer, T. (2008). Global health in Canadian medical education: Current practices and opportunities. Academic Medicine, 83(2), 192–198.

Joshua, J. H. (2024). Embracing global health in medical education: A necessity for modern doctors. JACC: Case Reports, 29(17).

Karadas, M., Bilgin, A., Sahan, F., & Ozdemir, L. (2023). Determining the predictors of nursing students' xenophobic tendency towards refugees. Nurse Education Today, 122, 105722. https://doi.org/10.1016/j.nedt.2023.105722

Karatekin, K., Akcaoglu, M. Ö., & Taban, M. (2019). A comparative study on multicultural attitude of university students: Austria, Hungary and Turkey sample. Journal of History Culture and Art Research, 8, 36. https://doi.org/10.7596/taksad.v8i4.2238

Köse Tosunöz, İ., & Çopur, E. (2024). The relationship between ethnocentrism and xenophobia level and predictors: A descriptive and correlational study of nurses working in two cities where refugees live intensively in Turkey. Nursing & Health Sciences, 26. https://doi.org/10.1111/nhs.13107

Kuehn, L. (2017). Creating a diverse workplace: The importance of multiculturalism in healthcare. Journal of Healthcare Management, 62(4), 265–267.

Pogge, T. (2006). Cosmopolitanism. In E. N. Zalta (Ed.), The Stanford Encyclopedia of Philosophy (Fall 2006 Edition). Stanford University. https://plato.stanford.edu/entries/cosmopolitanism/

Rojas, C., & Smith, L. (2009). The role of acculturation in health outcomes: A review of the literature. International Journal of Migration, Health and Social Care, 5(2), 24–30.

Sestito, M. (2025). Identity conflict, ethnocentrism and social cohesion. Journal of Development Economics, 174, 103426. https://doi.org/10.1016/j.jdeveco.2024.103426

Thomas, N. (2024). Diversity in the workforce: A catalyst for innovation, success and future expansion. Vol. 15. Indian Journal of Natural Sciences, 15(86), 80130–80137. http://www.tnsroindia.org.in

Ustymenko, T. (2018). The status of ethnocentrism in intercultural interaction, its types and functions. International Relations: Theoretical and Practical Aspects, 223–234.

Zhang, R., Hsu, H., & Wang, S. (2010). Global literacy: Comparing Chinese and US high school students. Multicultural Education & Technology Journal, 4(2), 76–98. https://doi.org/10.1108/17504971011052304

Zhang L., & Takahashi, Y. (2024). Both cosmopolitanism and ethnocentrism are positively associated with individual differences in global literacy. Personality and Individual Differences, 222, 112585. https://doi.org/10.1016/j.paid.2024.112585

Final Reflection: Relevance to Cultural Competence and the EMPOWER Model

by Małgorzata Szkup

The chapter „Globalization and multiculturalism in medical education and therapeutic teams" offers a comprehensive exploration of how global changes influence cultural diversity, healthcare delivery, and professional collaboration—perfectly aligning with the philosophy and objectives of the **EMPOWER model**. By addressing core themes such as **acculturation, ethnocentrism, global literacy, and inclusive team dynamics**, the chapter reinforces key pillars of EMPOWER: **Effectiveness, Multiculturalism, Professionalism, Wellness, and Education Resources.**

The discussion on **globalization and academic mobility** highlights how international exposure fosters reflective cultural competencies, one of the central goals of the EMPOWER model. It encourages future healthcare professionals to actively engage with intercultural contexts and adapt their clinical approaches accordingly. This supports the EMPOWER emphasis on self-directed learning and the **development of humility and awareness through transformative educational experiences.**

Furthermore, the chapter strongly promotes the concept of **cosmopolitanism**, which aligns with EMPOWER's core value of **cultural humility**—acknowledging the complexity of cultural identity and the need for ongoing reflection and mutual learning between healthcare professionals and diverse patient populations.

The section on **diversity in therapeutic teams** ties directly to EMPOWER's focus on **well-being** and **collaborative professional environments**. It demonstrates how multicultural teams foster innovation, inclusiveness, and effectiveness—mirroring EMPOWER's belief that personal and collective wellness is foundational to high-quality healthcare education and practice.

Finally, the chapter calls for **training in cultural competence and humility**, providing practical recommendations on how to minimize bias, appreciate cultural differences, and support inclusive communication—core principles of EMPOWER's educational strategy. This reflects the model's commitment to **equipping learners with the resources and support needed to transform theoretical understanding into effective, empathetic, and equitable practice.**

In summary, this chapter embodies the EMPOWER model in action: bridging global challenges with local practice, nurturing reflective professionals, and advocating for culturally responsive healthcare education.

Multi Culti Med

Chapter 4

Cultural Identity and Healthcare

MAGDALENA STANKIEWICZ
Pomeranian Medical University in Szczecin (Poland)

> **In every situation, we have a valid reason to choose the course of action that, according to reasonable predictions, will bring about the greatest good.**
>
> — Włodzimierz Galewicz
> "Goodness and justice in healthcare (2018)"

4.1. Introduction

Equitable and equal access to treatment and employment in medical professions requires an open approach that takes into account both the diverse needs of patients and the challenges faced by healthcare professionals. A key element is ensuring equality of access to employment in professions such as nursing, emergency medical services, and medicine, while simultaneously providing every patient with healthcare that respects their individuality. The foundation of effective and ethical medical practice lies in recognizing the patient as the subject of care, rather than its object, and treating them with full respect for their autonomy and dignity. Healthcare professionals must avoid reinforcing stereotypes, exploiting power dynamics, and objectifying patients, adopting an approach based on openness, empathy, and cultural awareness.

In situations of first contact with patients, it is important to adopt a needs- and expectation-based approach. Asking questions such as, **"How can I most effectively help?"** and **"What does this specific patient need?"** should be the starting point for every medical professional.

Intercultural competence and the ability to recognize the unique traits of each patient are essential to overcoming barriers to treatment access—both formal and communicative. Only through this approach can healthcare be provided that respects diversity and supports the effectiveness of therapeutic actions, based on partnership rather than hierarchy in the patient-professional relationship.

Medical professionals should be aware of communication barriers and biases that may influence their relationships with patients. Reflecting on one's own limitations and being prepared to overcome them are integral components of effective care. The openness to understand the cultural identity of others is also of particular importance. Differences in customs, views, attitudes towards the body, or religion should not be obstacles but sources of mutual respect and inspiration for building a deeper therapeutic relationship. Adopting this perspective, in which each patient is unique, not only supports the healing process but also enriches the professional practice of healthcare staff, making it more conscious and valuable.

Aims

Through this chapter students will enhance their attitudes, knowledge and skills in:

- Understanding the **importance of equal opportunities** for access to healthcare and the practice of medical professions, regardless of origin, social status, culture, religion, or gender identity.
- Strengthening an approach where the **patient is treated as the subject of care**, with full respect for their autonomy and dignity.
- Understanding the **significance of intercultural competence** in eliminating formal and communicative barriers in healthcare.
- **Promoting awareness and reflection** on personal biases and their impact on relationships with patients.

- Highlighting the **importance of openness and respect** towards patients' diverse customs, beliefs, and values.
- Understanding the **significance of gender identity** and the role it plays in an individual's sense of self.
- Understanding a**ttribution error mechanisms**, such as the fundamental attribution error and the false consensus effect, and their impact on the evaluation of patients and colleagues.
- Understanding the c**onsequences of unconscious assumptions** regarding gender identity and psychosexual orientation in professional practice.
- Understanding the **impact of racism and structural violence** on individual and community mental health, and recognizing the responsibility of healthcare professionals to address these issues through equitable, culturally competent, and ethically reflective practice.

Learning Outcomes

By the end of this chapter, readers will be able to:

- Define key concepts related to equal opportunities in healthcare and intercultural competence.
- Understand the impact of personal biases and cognitive error mechanisms on patient perception and decision-making in medical practice.
- Identify the differences between transgender and cisgender identities and describe the basic healthcare needs of transgender individuals.
- Analyze attribution errors and their consequences in the patient-doctor relationship and in intercultural communication.
- Explain how racism and structural violence affect mental health and describe the role of healthcare professionals in responding to these challenges through culturally competent and ethical practice.

Principles and Values

In the context of ensuring equal access to healthcare services and equal opportunities for employment in medical professions, key elements include fundamental ethical and social principles and values. These form the foundation of a just healthcare system, in which every patient, regardless of social status, origin, cultural identity, or other distinguishing factors, is guaranteed the right to high-quality medical care. At the same time, the system should guarantee fair employment conditions for healthcare professionals and provide opportunities for professional fulfillment without barriers arising from prejudice or discrimination (Prawo.pl, 2024). Values such as equality, justice, respect for patient autonomy, empathy, and professionalism play a crucial role in shaping ethical and effective medical practices, contributing to the improvement of healthcare quality and the building of public trust in the healthcare system.

In the context of ensuring equal access to healthcare services and employment opportunities in medical professions, the most important principles and values are:

- **Equality and Justice -** Every patient, regardless of their origin, social status, religion, or gender identity, should have equal access to healthcare. Justice in this context involves tailoring medical services to the individual needs of patients, rather than applying universal solutions.
- **Respect for Patient Autonomy** - Patients have the right to make independent decisions regarding their health. The role of healthcare professionals is to provide complete information, offer support, and create space for informed choices regarding treatment.
- **Empathy and Cultural Sensitivity** - Effective healthcare requires the ability to understand and respect cultural diversity, which influences patients' attitudes toward health and treatment. Openness to the needs of individuals from different backgrounds contributes to the elimination of prejudices and improves the quality of therapeutic relationships.
- **Professionalism and Medical Ethics** - Healthcare professionals should adhere to principles of professional ethics, such as care for the patient, confidentiality, honesty, and responsibility for the decisions made. Equality in employment also means removing barriers for those wishing to pursue medical professions, regardless of their background or gender.
- **Absence of Prejudices and Prevention of Discrimination** - Awareness of personal biases and the willingness to overcome them are key elements in building a just healthcare system. Any form of discrimination—in access to treatment or in the workplace—should be eliminated through appropriate regulations and practices.
- **Partnership in the Healthcare** Worker–Patient Relationship - Healthcare should be based on collaboration, not hierarchy. Patients and healthcare professionals should make treatment decisions together, which increases the effectiveness of therapy and improves the psychological comfort of the patient.

- **Accessibility and Inclusivity** - Every patient, regardless of educational level, language skills, or degree of disability, should have full access to medical services. Language barriers should be eliminated, informational materials should be adapted, and insufficient patient knowledge about different social statuses should be addressed.
- **Self-Improvement and Education** - Healthcare professionals should continuously develop their competencies, both in terms of medical knowledge and communication and intercultural skills. Training on diversity, equal treatment, and ethics should be an integral part of professional development (Bugaj, 2015).

Adopting these principles in daily medical practice will contribute to the creation of a more just, effective, and patient-sensitive healthcare system.

Relevant Definitions and Terms

To fully understand the concepts of equal access to healthcare and employment in medical professions, it is essential to clearly define several key terms:

- **Equity in healthcare** – a principle stating that every individual should have fair access to medical services, regardless of their socio-economic status, cultural background, gender identity, or other factors. The goal of this principle is to ensure that no group within society is disadvantaged when it comes to access to essential healthcare. Despite numerous initiatives aimed at promoting equal access to healthcare, disparities in its quality remain, particularly among minority groups, low-income individuals, and people with disabilities. These differences stem from systemic biases, financial barriers, and varying health literacy levels (Cianciara, 2015).
- **Cultural competence** – the ability of healthcare workers to understand, respect, and effectively interact with patients from diverse cultural backgrounds. It involves accepting different beliefs, values, and health practices. Numerous studies show that healthcare professionals who receive training in cultural competence are better able to provide quality care. This leads to higher patient satisfaction, better adherence to medical recommendations, and significantly better health outcomes (Cianciara, 2015).
- **Implicit bias** – unconscious attitudes or stereotypes that can influence decisions and interactions in healthcare settings. These biases can shape the behavior of healthcare professionals and impact the quality of care provided to patients. Implicit bias can lead to differences in treatment recommendations, pain management, and diagnostic accuracy. For example, studies have shown that Black patients often receive insufficient pain relief compared to other patients, stemming from incorrect assumptions about their pain tolerance (Strzemięczna, 2020).
- **Patient-centered care** – a healthcare model that prioritizes the individual needs, preferences, and values of the patient, enabling them to actively participate in the decision-making process regarding their own treatment.
Social determinants of health – non-medical factors such as income level,

education, living conditions, and cultural background, which significantly influence an individual's health and access to medical services.

- **Health disparities** – differences in health outcomes and access to healthcare between different population groups, often resulting from socio-economic inequalities, systemic discrimination, and geographic barriers.

> *"Doctors who care for the sick must understand what a human being is, what life is, and what health is, and how the balance and harmony of these elements sustain them."*
>
> *– Leonardo da Vinci*

4.2. The Patient as a Subject in the Healthcare System

In order for healthcare to be effective and equitable, it must take into account the diverse needs arising from patients' traditions, beliefs, values, and cultural practices. In the context of globalization and migration, healthcare professionals increasingly encounter patients from various cultural backgrounds, which requires not only high professional competence but also intercultural skills. Understanding and respecting these differences is crucial for effective communication, building trust, and tailoring treatment methods to the specific needs of patients. Therefore, analyzing the relationship between cultural identity and healthcare is an essential element in improving healthcare systems, promoting a holistic and individualized approach to each patient (Tabaszewski, 2016).

Respect for human rights, especially in the context of health, is a fundamental element of modern human rights protection systems. While many international health organizations and legal acts broadly promote these rights, significant challenges remain in their actual implementation. Theories on tolerance for diversity, although often expressed in words, do not always translate into practical actions (Tabaszewski, 2016). The full integration of health with human rights is also problematic, as the catalogue of these rights does not clearly specify principles in this area. Despite increasing migration, the number of international exchange programs, and the employment of workers from different countries, the concept of equality and diversity still poses a challenge in healthcare institutions (Tabaszewski, 2016).

Human rights, particularly the right to health protection, constitute an inalienable foundation of an individual's membership in the human species. These rights, characterized by universality, inviolability, and equality, are deeply rooted in human dignity. Achieving equality in access to healthcare and fully respecting the uniqueness and dignity of each individual is a key challenge in contemporary medicine and law (Tabaszewski, 2016).

Respect for human rights, especially concerning health, is a widely discussed topic in many legal documents and by organizations concerned with health worldwide. While international documents, such as the United Nations Charter, the Universal

Declaration of Human Rights, and the Alma-Ata Declaration, clearly emphasize the right of every human being to health, decent living conditions, and comprehensive care, reality often deviates from these ideals. People around the world continue to get lost in bureaucratic complexities and fall victim to systemic neglect. This issue is particularly evident in the context of the right to health, which remains one of the most ambiguous and challenging to implement in practice (Murphy, 2013).

Are legal provisions enough to change this? These documents set standards, but the realization of these rights depends on our empathy, engagement, and willingness to provide real assistance. Each of us, as citizens and members of society, can contribute to ensuring that human rights are not just words on paper. Change begins with action, with small steps toward creating a system where everyone feels seen, heard, and supported. The implementation of comprehensive actions based on respect, empathy, and effectiveness is the only way for international regulations to become a reality, not just a promise written in legal texts.

Healthcare protection, especially on an international scale, is related to the responsibility of states to create systems that ensure the protection of health for both citizens and foreigners. This includes various actions aimed at realizing human rights in the field of health. States should implement effective mechanisms that maintain an individual's health status quo (Banaszak, 2003). However, migrants often face various obstacles in accessing healthcare. The main difficulties are related to communication, cultural, and systemic barriers, which constitute significant challenges for both patients and healthcare professionals (Strzemięczna, 2020). Many healthcare workers struggle with language barriers, which significantly hinders the effective delivery of healthcare services. Studies conducted within this group show that language is the primary obstacle in providing adequate care to patients who speak foreign languages (Zgliczyński & Cianciara, 2020).

4.3. Cultural Identity and Healthcare

Understanding cultural identity is crucial in providing effective healthcare. Cultural identity refers to the values, beliefs, customs, and practices that shape a person's way of life. It influences how individuals perceive health, illness, and medical care.

Why is this important in healthcare?
- *It helps build trust and good relationships with patients.*
- *It improves communication and reduces the risk of misunderstandings.*
- *It increases patient satisfaction and improves treatment outcomes.*

The study of cultural identity in healthcare involves four key steps that help understand the patient within the context of their cultural background. The process begins with **self-reflection**, which requires recognizing one's own biases and understanding how our cultural background influences the way we perceive

patients. After each interaction with a patient, it is important to reflect on how culture might have impacted the conversation. Next, in order to better understand the patient, **open-ended questions** should be asked, encouraging them to share their beliefs and perspectives, such as inquiring about family approaches to illness or specific spiritual practices. Equally crucial is **learning and observation**, which include both non-verbal communication and gaining knowledge about the culture of the community being served. Finally, healthcare must be **adapted to the patient's needs** by incorporating their cultural practices into the treatment plan and maintaining a flexible approach that respects their beliefs and values (Strzemięczna, 2020).

In building relationships, a simple phrase such as "**How can I help?**" can be highly beneficial. It carries a strong emotional charge while not being limited to any specific cultural, social, or individual conditions. It has been designed to be understood and applied by any person, regardless of their cultural or social background. This phrase focuses on offering support and assistance in an open manner, irrespective of any differences. It demonstrates respect for the needs of another person, regardless of their context. Rather than assuming someone may need help in a specific way, it provides space for the patient to define their own source of suffering. This is an expression of universal readiness to understand and adapt to different perspectives and situations.

Such a formulation supports the idea of equality and respect for diversity. It helps break down barriers and build bridges between different cultures and communities, as it is a question that does not discriminate but takes into account the individual needs of each person. It is a universal invitation to interact, expressing a willingness to collaborate and understand one another, no matter the background of the individual in question.

Madeleine Leininger, as a nurse and anthropologist, was one of the pioneers in understanding the influence of cultural background on health and healthcare.

Madeleine Leininger
Source: The South Swedish Medical History Society (SMHS)

She developed the theory of transcultural nursing, which emphasized the importance of incorporating the cultural background of patients into the treatment process. Her research in the 1950s focused on how crucial it is to understand cultural aspects in the context of healthcare, particularly concerning children's mental health (Leininger, 1981).

4.4. Cultural Determinants of Health and Disease

Culture plays a significant role in shaping human health, influencing it in various aspects. It is valuable to examine its impact from three perspectives. Culture can act as:

- **A pathogenic factor** - it can increase the risk of certain diseases, for example, due to specific dietary habits, smoking, or alcohol consumption.
- **A therapeutic factor** - it can promote health-enhancing behaviors, such as fostering community, social support, or healthy eating habits.
- **A pathoplastic factor** - it can significantly influence the perception and expression of symptoms, particularly in the context of mental disorders. For example, depression symptoms may vary across cultures: in Latin America, they are more often manifested as headaches, in the Middle East as cardiovascular issues, and in Asia as a sense of weakness (Grzymała-Moszczyńska, 2007).

Culture can influence both the prevalence and the way mental disorders are manifested in various ways:

- **Pathogenicity:** culturally shared beliefs or ideas can directly generate stress, contributing to the development of mental disorders;
- **Pathoselectivity:** during stressful situations, individuals may adopt culturally accepted coping responses;
- **Pathoplasticity:** cultural beliefs shape how the symptoms of mental illness are expressed and perceived;
- **Pathoelaborative effects:** culture can intensify certain pathological behaviors, making them more pronounced and persistent;
- **Pathofacilitative effects:** cultural factors may affect how often a disorder occurs or the form in which it appears.
- **Pathoreactivity:** culture influences how society responds to mental illness—this affects both how disorders are labeled and how suffering is experienced and communicated by those affected (Bhugra & Bhui, 2018).

Examples of Cultural Health Determinants:

- **Dietary Practices:** In Hinduism, there is a belief in the sanctity of all living beings, which leads many followers to adopt a vegetarian diet. Avoiding meat consumption, especially beef, stems from respect for life and religious beliefs. In India, cows are particularly revered, and their meat is not consumed due to religious convictions (Śmidowicz, 2016).
- **Alcohol Consumption:** In Muslim countries, where alcohol consumption is prohibited, the risk of alcohol-related diseases is much lower. In contrast, in countries where alcohol consumption is accepted, such as France, the risk of liver cirrhosis is higher (Krajewska-Kułak, 2010).
- **Sexual Behaviors:** Cultural norms shaping attitudes toward sexual orientation, the age at which marriage occurs, or the use of contraception, significantly affect sexual health. In the Roma culture, early marriages of younger girls are common, which can have specific health consequences (Krajewska-Kułak, 2010).

- **Body Modifications:** Male circumcision, which in some cultures has religious significance (Judaism, Islam, and some African tribes), is performed in other regions for reasons not necessarily related to religion, as seen in the United States (Grzymała-Moszczyńska, 2007).
- **Cultural Influence on Mental Health:** In the case of paranoid schizophrenia, the content of delusions often reflects cultural context - individuals who practice Christianity and Islam are more likely to experience religious delusions, people from Asia may have delusions of infidelity, and individuals from Africa often struggle with delusions related to the local community (Krajewska-Kułak, 2010). It is also important to note that certain disorders are found only in specific cultures, such as koro – an anxiety disorder observed mainly in Southeast Asia, characterized by the belief that the genitals are shrinking (Krajewska-Kułak, 2010).
- **Alternative Medicine and Cultural Beliefs:** In many communities, there is a strong belief in traditional medicine, which includes both home remedies and more formalized medical systems, such as Chinese medicine or Ayurveda. The effectiveness of these methods is often

4.5. Challenges in Medical Practice

The complexity of culture's impact on health presents medical practitioners with a series of challenges, necessitating the consideration of cultural context in diagnosis and therapy.

- **Touch and Exposure of the Body:** In many cultures, physical contact with certain parts of the body, particularly those of the opposite gender, is regarded as unacceptable. This cultural perception may lead to refusal of medical examinations or procedures (Grzymała-Moszczyńska, 2007).
- **Consent for Medical Procedures:** The issue of consent for medical procedures, such as organ transplantation, is often complex. In some communities where such actions are seen as contrary to their religious beliefs, this issue takes on particular significance. This can be relevant for certain ethnic groups, such as the Roma, as well as for followers of Buddhism or Shintoism (Krajewska-Kułak, 2010).
- **Gender Identity:** Until the 1960s, discussions about gender predominantly focused on masculinity and femininity, which were considered opposite ends of a single continuum. It was believed that a person could be either feminine or masculine, regardless of whether they were a homosexual man or a homosexual woman—the key factor was the subjective sense of one's gender (Bem, 2010). However, Sandra Bem challenged this traditional viewpoint. She proposed that masculinity and femininity are two distinct dimensions of personality. As a result of this perspective, the concept of androgynous individuals emerged, who could exhibit both masculine and feminine traits simultaneously. Bem's concept focuses on two key assertions regarding the formation of an individual's gender identity (Bem, 2010).

When considering terms such as transsexuality, non-binarity, and androgyny, it is important to take into account the social, clinical, and legal contexts of a given country. Research from centers specializing in transition-related topics provides valuable insights into contemporary trends among youth and the medical consequences associated with gender issues. **Transsexuality** refers to individuals whose gender identity does not align with the sex assigned at birth. These individuals often opt for corrective surgeries, hormone replacement therapy, or other methods to change their appearance in order to better reflect their gender identity. Transsexual individuals may identify as men or women, irrespective of their biological sex. **Non-binary individuals**, on the other hand, do not identify strictly as men or women but instead exist outside the traditional binary gender categories. Non-binarity is often viewed as a continuum, and non-binary individuals may use various pronouns such as "they," "them," or "it." **Androgynous individuals** combine both masculine and feminine traits in varying proportions, and may display characteristics of both genders, as well as experiment with diverse styles of dress and behavior. These individuals avoid rigid gender classification, allowing for greater exploration of their gender identity (Titelbaum, 2020).

It is important to note that these three terms are not mutually exclusive and may overlap. A transsexual person may identify as non-binary or androgynous, just as a non-binary person can also be androgynous or transsexual. According to the most common and widely accepted approach, non-binarity serves as an umbrella term for all gender identities that fall outside the binary gender division. Non-binary individuals are neither men nor women. They often identify as agender, gender-neutral, or genderfluid. This term also includes individuals who identify with more than one gender. Within the LGBTQ+ community, non-binary individuals represent both the "T" (transgender) and "Q" (genderqueer) categories (Haak, 2020).

Non-binary individuals are, by definition, transgender. They experience a mismatch between their biological sex and gender identity. Some may also experience gender dysphoria. In 2019, the word "non-binary" was added to the Collins Dictionary (Haak, 2020). This does not mean the term is new but rather reflects growing societal awareness of the diversity of gender identities and expressions. The term "genderqueer" gained popularity in the mid-1990s. Riki Anne Wilchins is closely associated with this concept, particularly due to her significant contribution to the publication Genderqueer: Voices Beyond the Sexual Binary (2002). In 1995, Wilchins released the pamphlet In Your Face, in which she first used the term genderqueer. In this publication, the term referred to individuals with complex or undefined gender expressions, which differs from its modern definitions (Wilchins, 1995).

In Western Europe, the concept of non-binary gender, often referred to as the "**third gender**" is gaining prominence within the emerging gender culture of the last decade. Historically, it has been widespread and documented in Central Africa, the Americas, Asia, and Oceania. In India, Bangladesh, and Pakistan, there exists a social group known as the hijras. These individuals are assigned male at birth (AMAB) but function outside of the male gender. Most hijras identify as non-binary, even though their appearance is stereotypically feminine (Haak, 2020). Indian hijras represent a simple, widely recognized, and extensively documented example of a "third gender" that is fully integrated into society.

Reading about the Amazons, women who bravely fought in wars, provides a clear image that gender does not determine social roles. In Benin, Africa, individuals assigned female at birth (AFAB) but exhibiting culturally male traits were called "mino" and fought in wars alongside men, without having children or entering into relationships with men (which was expected of women at that time). Today, in Benin, women are responsible for tasks requiring strength and precision, such as carrying water, a task forbidden to men (Krzemińska, 2023).

In North America, increasing visibility is being gained by Indigenous American individuals who identify as "two-spirit" (Haak, 2020). The term "Two-Spirit" was introduced by Myra Laramee in 1990. It derives from the Anishinaabe word niizh manidoowag, describing individuals with both masculine and feminine traits. One of the most commonly cited meanings refers to a person who possesses both male and female souls (Jacobs, et al., 2021). Some tribes recognize as many as four genders, while others have their own gender-specific terms. Exploring the cultural significance of gender, including its naming and sense, reveals fascinating examples such as the pre-colonial Hawaiian society, which was a multi-gender society (Titelbaum, 2020).

In English, non-binary individuals use the singular "they" instead of the gendered "he" or "she." This approach has been reinforced by the American Psychiatric Association, which also recommends using "they" in the singular when an individual's gender identity is unknown (Haak, 2020).

Understanding these differences is crucial for effective healthcare. Medical professionals and other healthcare workers should remember that a patient is not just a body to be healed but also a collection of values, norms, and beliefs that must be

respected throughout the treatment process. Only then will healthcare be effective and tailored to the individual needs of the patient. Acknowledging cultural differences not only improves the quality of care but also enriches the medical profession, highlighting the importance of empathy and respect in the healing process.

4.6. Psychological Mechanisms Affecting the Formation of Multicultural Relationships in the Medical Environment

Awareness of Our Prejudices: The division between "us" and "them" is a phenomenon present in every social group, regardless of origin, hierarchy, or the values it adheres to. Categorizing oneself as "we" and distinguishing others as "they" or "them" is one of the fundamental mechanisms that helps people navigate the world around them. It is likely that the root cause of this phenomenon lies in the need to clearly identify groups that posed a threat or, at the very least, were foreign, thus requiring caution and appropriate protective actions. The awareness of being part of "our own" creates a strong sense of belonging and security. As social beings, people express this particularly in their relationships with others, often unconsciously emphasizing their belonging to a particular community (Citlak, 2018).

Projection Biases: refer to a phenomenon in which an individual assumes that others think and feel the same way they do. In psychology, this mechanism is referred to as "projection" and is considered one of the defense mechanisms. Projection involves attributing one's own thoughts, emotions, or traits to other people, often based on the assumption that others share similar beliefs or feelings. This is a way in which an individual transfers their internal experiences onto external people or situations, assuming their perception and understanding of the world align with their own. In reality, however, each person is unique, with distinct thinking and perceptual processes, which means that others' perceptions of reality and emotions may differ from our own. Therefore, recognizing each individual's right to their own perspective and interpretation of the world is a fundamental aspect of their autonomy and dignity (Claney, 2024).

Another term that may be related to this phenomenon is "**false consensus**". This is a cognitive bias in which one assumes that the majority of people think, feel, and act in the same way they do, particularly in situations where their own beliefs or behaviors are not widely shared (Chodkowski, 2017). Both of these mechanisms can lead to misunderstandings as they fail to account for individual differences in thinking, feeling, and perceiving reality.

An empathetic approach to a situation, particularly in understanding the context of another person's functioning, especially in relation to a patient, helps us better understand their point of view and perspective. People often make attribution errors when attempting to understand others' behaviors, not fully appreciating the significance of situational factors. Instead, they focus on internal traits or predispositions of individuals, even though external factors could fully explain the observed behavior. This type of error is known as the correspondence error or

fundamental attribution error. It is more prevalent in Western cultures, such as those in Europe or the United States, than in countries in the Far East, which is linked to differences in socialization processes and perceptions of social situations (Chodkowski, 2017).

Another interesting phenomenon related to attributional errors is **attributional egotism**. This manifests as attributing one's successes to internal traits, while attributing failures to external factors. This way of thinking strengthens our sense of responsibility for our successes, while minimizing our responsibility for failures, acting as a defense for our "self" and boosting our self-esteem (Chodkowski, 2017).

The last century has provided substantial evidence supporting the claims of social psychologists regarding the profound, if not total, impact of situations on human actions. The Second World War, with its horrific consequences in the form of concentration camps and mass extermination, shocked our previous understanding of human nature. The ongoing war in Ukraine, with its unfolding horrors and countless cases of brutality and cruelty, has become a key reference point in studies on how situations shape individual behaviors. In this context, it is important to revisit the wellknown, though controversial, experiment that contributed significantly to our understanding of human nature—the Stanford Prison Experiment by Philip Zimbardo.

Zimbardo's research was one attempt to explain the phenomenon of new evil (Zimbardo, 2017). The conclusions drawn from the experiment clearly suggested that the situations created by the prevailing system are the source of evil and the transformation of good people into depraved and cruel beings. The Stanford Prison Experiment aimed to understand how quickly ordinary people could be transformed into individuals exercising power or falling victim to it due to specific social conditions. The participants were students who underwent personality and intelligence tests to eliminate factors that could distort the experiment's results. The selection criteria focused on factors like similar education, age, social status, and a lack of criminal background or psychological disorders. Twenty-four students were randomly selected to participate in the experiment, where they were divided into two groups: prisoners and guards. They were given special clothing to accentuate the differences between the two groups; prisoners wore identical shirts

Philip Zimbardo
Source: Courtesy of Ferne Millen Photography. Accessed June 6, 2025, from https://philipzimbardo.com/

with embroidered numbers, while guards wore uniforms resembling soldiers' attire, with specific attributes like batons and glasses. Those assigned the role of guards were instructed on the nature of their roles. Their task was to monitor the prisoners as effectively as possible, using appropriate means. The only condition was an absolute prohibition of physical violence. The experiment was designed to last for two weeks, but due to the dramatic course and the intensity with which the expected effects emerged, as well as concerns for the students' psychological and physical health, it was stopped after one week. The first student-prisoner was released after only 36 hours due to clear signs of mental breakdown.

Zimbardo concluded that the changes and pathological behaviors observed were not a result of the students' personalities but rather situational factors supported by the system—defined as the conditions and limitations imposed at the start of the experiment. He argued that the system in which individuals function shapes their attitudes and behaviors, and people are merely actors playing predetermined roles. Their behaviors—behavioral scripts—are strictly defined by the situations, and thus, by the system. As Zimbardo put it: "The system consists of agents and institutions whose ideology, values, and power create situations and dictate roles and expectations for approved behaviors of actors within its spheres of influence" (Zimbardo, 2017). Zimbardo's theory suggests that individuals who occupy specific roles within a given system are not traditionally responsible for their actions. Instead, they conform to the role imposed upon them, and their behavior is a result of the situation in which they find themselves, and the expectations that the system—the environment in which they are placed with assigned roles—imposes upon them (Zimbardo, 2017).

The role of a healthcare provider who intervenes in the area of health and provides medical assistance bestows a unique situational advantage, considered in terms of authority. The patient and their loved ones entrust not only their health but often their lives into the hands of professionals. This relationship is based on exceptional trust, which carries the responsibility for decisions concerning the most valuable thing: human life. In this context, it is crucial to remember that the patient is not an object of treatment, but a subject— a person with a unique background, culture, faith, gender, and other defining characteristics of their identity. Therefore, it is of fundamental importance to overcome any barriers to access to treatment— from formal obstacles to communication barriers. Effective care requires awareness and openness to patient diversity, which is an indispensable condition for accurately identifying their needs and implementing appropriate therapeutic actions. Without understanding the individual circumstances of the patient, it is difficult to speak of a holistic and effective approach to treatment. Moreover, there is undeniable evidence of the impact of a patient's mental attitude on the treatment and recovery process. A positive attitude can significantly support therapeutic efforts, and cultivating it requires empathy, understanding, and consideration of each patient's unique context. Only through a conscious and open approach can optimal results in healthcare be achieved.

4.7. Racism and Structural Violence as Determinants of Mental Health – The Role of Medical Professionals

The concept of race emerged in Europe in the 18th century with the rise of colonialism and the development of the natural sciences. Initially, it was used to classify animals and later humans. It is one of the most controversial social and scientific constructs in modern history (Smedley, 2005).

According to the Oxford Dictionary (2018), race is a system of classifying people into large, distinct populations or groups based on hereditary external characteristics (phenotype), geographical origin, culture, history, language, ethnicity, and social status. In the early 20th century, the term was often used in a taxonomic sense to emphasize the genetic diversity of human populations defined by phenotype.

Racial classification began with Carl Linnaeus (1758), who divided humanity into four groups: Europeans, Africans, Asians, and Americans. Johann F. Blumenbach (1795) introduced a different classification: Caucasian, Mongolian, Malay, Ethiopian, and American. Surprisingly, we can still find this classification today. Advances in human genetics have shown that these categories are arbitrary (Yudell, 2011).

UNESCO has played an important role in eradicating this scientific and social concept. In its 1950 Declaration, it affirmed that races do not exist in biological terms but are social constructs with no genetic basis. In subsequent declarations, it refuted the scientific basis of racism, just as in 1978 it reaffirmed the nonexistence of biological races and broadened the focus to include sociohistorical factors: "Differences in achievement among peoples are explained by geographical, historical, political, economic, social, and cultural conditions, not by biological determinants." UNESCO documents, translated into 87 languages, inspired legal instruments such as the International Convention on the Elimination of All Forms of Racial Discrimination (1965).

Anthropology proposes replacing the term race with population or ethnicity. The goal is to disassociate human diversity with pseudobiological hierarchies. The UNESCO declarations marked a milestone in this deconstruction. Overcoming racism requires not only scientific evidence but also political will.

Racism is a recognized risk factor for both mental and physical health. It affects not only individuals but entire communities through its impact on the micro (personal), meso (institutional), and macro (structural) levels. Understanding these mechanisms and their consequences is crucial for future healthcare professionals who are expected to provide equitable and culturally competent care.

As shown by Schouler-Ocak and Moran (2023), racism takes many forms—from interpersonal prejudice and microaggressions to systemic inequalities in access to employment, education, and healthcare. Experiences of racial discrimination have been documented to increase the risk of **depression, anxiety, PTSD, psychotic disorders**, and **substance misuse**. The authors also highlight the **neurobiological consequences** of chronic stress associated with discrimination, including reduced volume of white and gray brain matter and hyperactivity of the amygdala.

Schouler-Ocak, et al. (2021) emphasize the need to integrate the topic of racism into professional training and clinical practice in psychiatry. Their report includes recommendations for clinicians and policymakers to address the impact of racism on mental health at every level—from education to research to clinical care.

A key aspect is the recognition and prevention of both internalized and institutional racism, as well as the need for critical reflection on social and cultural privilege. Jarvis, et al. (2023) propose concrete anti-racist strategies at three levels:

- **Micro:** self-reflection, recognizing personal bias, developing cultural competence, and readiness to talk about racism with patients.
- **Meso:** reforming educational programs, hiring equity and diversity officers, and restructuring institutions.
- **Macro:** advocacy, public policy reform, and combating environmental and structural violence.

Integrating these perspectives into medical education fosters a mindset of active professionalism consistent with the EMPOWER model, which promotes reflection, justice, and a holistic approach to patient care.

References

Banaszak, B., et al. (2003). *System ochrony praw człowieka*. Kraków.

Bem, S. (2000). Męskość i kobiecość. *O różnicach wynikających z płci*. Gdańskie Wydawnictwo Psychologiczne.

Bhugra, D., & Bhui, K. (Eds.). (2018). *Textbook of cultural psychiatry*. Cambridge University Press.

Blumenbach, J. F. (1795). *De generis humani varietate nativa* (Originally published as dissertation, 1775). Gottingae: Vandenhoek et Ruprecht. https://archive.org/details/degenerishumaniv00blum

Bugaj, J. M. (2012). Rozwój kompetencji zawodowych pracowników medycznych. In M. Bugdol, J. Bugaj, & I. Stańczyk (Eds.), *Procesy zarządzania zasobami ludzkimi w służbie zdrowia* (pp. 75–102). Continuo, Państwowa Medyczna Wyższa Szkoła Zawodowa.

Chodkowski, Z. (2017). *Zarys charakterystyki komunikacji interpersonalnej, możliwe zakłócenia i bariery*. Kultura – Przemiany – Edukacja.

Cianciara, D. (2015). Przyczyny i przyczyny przyczyn nierówności w zdrowiu. *Hygeia Public Health*, 50(4), 435–441.

Citlak, A. (2018). Psychologiczne i językowe uprzedmiotowienie obcych (stereotypizacja i dehumanizacja wrogów). *Studia nad Autorytaryzmem i Totalitaryzmem*, 40(4). https://doi.org/10.19195/2300-7249.40.4.1

Claney, C. (2024). *Projection as a defense mechanism: Understanding the psychology behind it*. Relational Psych. https://www.relationalpsych.group/articles/projection-as-a-defense-mechanismunderstanding-the-psychology-behind-it

Grzymała-Moszczyńska, H. (2007). Uchodźcy jako wyzwanie dla polskiego systemu opieki zdrowotnej. In K. Klaus (Ed.), *Migranci na polskim rynku pracy*. Rzeczywistość, problemy, wyzwania. Warszawa.

Haak, D. (2020, 9 kwietnia). *Niebinarność oraz język neutralny płciowo*. PPM. https://ppm.umb.edu.pl/info/article/UMBc43009d2b07945598720ee82c58107dc

Jacobs, S. E., Thomas, W., & Lang, S. (1997). *Two-Spirit People: Native American Gender Identity, Sexuality, and Spirituality*. University of Illinois Press. https://transreads.org/wpcontent/uploads/2021/07/2021-07-22_60f978648ad9b_3175882.pdf

Jarvis, G. E., Andermann, L., Ayonrinde, O. A., Beder, M., Cénat, J. M., Ben-Cheikh, I., Fung, K., Gajaria, A., Gómez-Carrillo, A., Guzder, J., Hanafi, S., Kassam, A., Kronick, R., Lashley, M., Lewis-Fernández, R., McMahon, A., Measham, T., Nadeau, L., Rousseau, C., Sadek, J., Schouler-Ocak, M., Wieman, C., & Kirmayer, L. J. (2023). Taking action on racism and structural violence in psychiatric training and clinical practice. *The Canadian Journal of Psychiatry*, 68(10), 780–808. https://doi.org/10.1177/07067437231166985

Klaus, K. (2007). *Migranci na polskim rynku pracy*. Rzeczywistość, problemy, wyzwania. Warszawa.

Krajewska-Kułak, E., Wrońska, I., & Kędziora-Kornatowska, K. (2010). *Problemy wielokulturowości w medycynie*. PZWL.

Krzemińska, A. (2023). *Kobiece ramię zbrojne, czyli co wiemy o wojowniczkach z Dahomeju*. Projekt Pulsar. https://www.projektpulsar.pl/czlowiek/2202236,1,kobiece-ramie-zbrojne-czyli-co-wiemyo-wojowniczkach-z-dahomeju.read

Leininger, M. (1981). *Transcultural Nursing: Concepts, Theories, Research & Practice*. McGraw-Hill.

Murphy, J. (2013). *Health and Human Rights*. Oxford-Ortland-Oregon.

Linnaeus, C. (1758). *Systema naturae* (Vol. 1, 10th ed.). Holmiae: Impensis Direct. Laurentii Salvii. https://www.biodiversitylibrary.org/item/10277

Schouler-Ocak, M., Bhugra, D., Kastrup, M. C., Dom, G., Heinz, A., Küey, L., & Gorwood, P. (2021). Racism and mental health and the role of mental health professionals. *European Psychiatry*, 64(1), e42. https://doi.org/10.1192/j.eurpsy.2021.2216.

Schouler-Ocak, M., & Moran, J. K. (2023). Racial discrimination and its impact on mental health. *International Review of Psychiatry*, 35(3–4), 268–276. https://doi.org/10.1080/09540261.2022.2155033.

Oxford English Dictionary. (2018). *Race*. In Oxford English Dictionary (3rd ed.). https://www.oed.com/dictionary/race_n1

Parra, E. J., Kittles, R. A., & Shriver, M. D. (2004). Implications of correlations between skin color and genetic ancestry for biomedical research. *Nature Genetics*, 36(11 Suppl), S54–S60. https://doi.org/10.1038/ng1440

Prawo.pl. (2024). *Dyskryminacja w środowisku medycznym jest poważnym problemem*. Prawo.pl. https://www.prawo.pl/zdrowie/dyskryminacja-w-srodowisku-medycznym,530399.html

Smedley, A., & Smedley, B. D. (2005). Race as biology is fiction, racism as a social problem is real: Anthropological and historical perspectives on the social construction of race. *American Psychologist*, 60(1), 16–26. https://doi.org/10.1037/0003-066X.60.1.16

Strzemięczna, A. (2020). *Publiczny system opieki zdrowotnej wobec cudzoziemców: Badania na terenie województwa mazowieckiego*. Warszawa.

Sztejnberg, A. (2001). *Podstawy komunikacji społecznej w edukacji*. Astrum.

Śmidowicz. (2016). *Kulturowe uwarunkowania zachowań żywieniowych*. DocPlayer. https://docplayer.pl/158531363-Kulturowe-uwarunkowania-zachowan-zywieniowych.html

Tabaszewski, R. (2016). *Prawo do zdrowia w systemach ochrony praw człowieka*. Wydawnictwo KUL.

Titelbaum, J. (2020). *The Evolution of Gender and Gender Identity in Contemporary Society*. Lectures on the Psychology of Women. McGraw-Hill Education.

United Nations. (1965). *International Convention on the Elimination of All Forms of Racial Discrimination*. https://www.ohchr.org/en/instruments-mechanisms/instruments/internationalconvention-elimination-all-forms-racial

Wilchins, R. A. (1995). *In your face. Political Activism against gender oppression*. Digital Transgender Archive. https://www.digitaltransgenderarchive.net/downloads/1831ck00f

Yudell, M. (2011). A Short History of the Race Concept. In S. Krimsky & K. Sloan (Ed.), *Race and the Genetic Revolution: Science, Myth, and Culture* (pp. 13-30). New York Chichester, West Sussex: Columbia University Press. https://doi.org/10.7312/krim15696-002

Zgliczyński, W., & Cianciara, D. (2020). *Badania nad barierami komunikacyjnymi w opiece nad cudzoziemcami*. Warsaw Enterprise Institute.

Zimbardo, P. (2017). *Efekt Lucyfera* (A. Cybulko, J. Kowalczewska, J. Radzicki, & M. Zieliński, tłum.). PWN.

Final Reflection: Relevance to Cultural Competence and the EMPOWER Model

by Małgorzata Szkup

This chapter illustrates that cultural identity is not a peripheral concept in medicine, but rather a **foundational element** in the delivery of **ethical, effective**, and **person-centered care**. By acknowledging the role of cultural values, beliefs, and traditions in shaping patients' experiences and perceptions of health and illness, the chapter aligns closely with the principles of the EMPOWER model—particularly those of Multiculturalism, Wellness, Professionalism, and Education Resources.

The emphasis on **treating the patient** as a subject rather than an object of care underscores EMPOWER's call for dignity, autonomy, and partnership in the patient-provider relationship. Students and professionals are reminded that the success of therapeutic interventions depends not only on clinical competence but also on **cultural sensitivity, mutual respect**, and **open communication**. This aligns with EMPOWER's commitment to empathy, equity, and human rights as essential components of healthcare practice.

The chapter's discussion of implicit bias, attribution errors, and projection mechanisms offers insight into the psychological processes that often go unexamined in clinical encounters. These mechanisms—when left unaddressed—can lead to miscommunication, misdiagnosis, and reduced quality of care. The EMPOWER model encourages professionals to develop self-awareness and reflective practices to recognize and mitigate such biases, supporting more accurate, respectful, and inclusive interactions.

Furthermore, the chapter expands on the **consequences of systemic racism and structural violence**, reinforcing the EMPOWER model's view that equitable healthcare requires not only interpersonal awareness but also **institutional change**. By recognizing racism as a determinant of mental health, the text calls for action on the micro (personal), meso (organizational), and macro (policy) levels—exactly the type of multi-tiered engagement EMPOWER promotes.

Finally, by integrating insights from transcultural nursing, global human rights frameworks, and social psychology, the chapter demonstrates that healthcare rooted in cultural competence is both **morally imperative** and **practically necessary**. This approach prepares students not only to serve diverse populations, but also to become agents of change—advocating for justice, inclusivity, and integrity in healthcare systems.

In this way, the chapter provides not only a conceptual foundation but also a direct pathway for applying the EMPOWER model in clinical education and practice, promoting holistic, just, and human-centered care.

Multi Culti Med

Chapter 5

Intercultural Competence:

Changing Perspective & Reflexive Competence

MARIA ANNA MARCHWACKA
Ostfalia Hochschule fur angewandte Wissenschafen (Germany)

> **It's all about changing perspective and reflexive competence!**

5.1. Introduction

In healthcare and nursing, diversity is not just a reality—it is a defining factor of professional practice. Every interaction, whether with patients, colleagues, or caregivers, is shaped by different cultural backgrounds, values, and communication styles. While this diversity enriches the healthcare system, it also requires us to develop a heightened awareness of how cultural factors influence care. Misunderstandings—whether linguistic or cultural—can hinder patient-centered approaches and, in some cases, even compromise patient safety. **How can we, as healthcare professionals, become more sensitive to cultural differences? How do we develop the ability to shift perspectives and reflect on our own biases?**

Intercultural competence in healthcare is not about rigid rules, but about developing a self-reflective, adaptable mindset that fosters inclusive, patientcentered care.

This chapter explores the concepts of migration, culture, interculturality from an educational perspective. It highlights the importance of **reflexivity, sensitivity, and perspective-taking** as essential components of intercultural competence. A didactic approach is introduced that supports healthcare professionals in recognizing their own cultural influences, questioning assumptions, and engaging in meaningful interactions with individuals from different backgrounds.

Intercultural competence is not about mastering a set of predefined rules—it is about cultivating an open, self-reflective mindset that allows us to adapt, learn, and grow in an increasingly interconnected world. By embracing this process, we can contribute to a healthcare system that is not only professional and efficient but also truly inclusive and human-centered. Let's embark on this journey of reflection and learning, shaping a future where diversity is seen not as a challenge, but as a strength.

Aims

Through this chapter students will enhance their attitudes, knowledge and skills in:

- The development of cultural sensitivity in the context of patient interaction
- The enhancement of interdisciplinary and intercultural teamwork within various healthcare settings
- The training of effective and culturally sensitive communication techniques in the context of multicultural patient care
- The assurance of patient safety while considering cultural diversity
- The development of a diverse healthcare organization

Learning Outcomes

By the end of this chapter, readers will be able to:

- Reflect on their personal perspective
- Develop perspective-taking skills
- Identify synergies between perspectives
- Switch perspectives and adopt multiple viewpoints

5.2. Culture – Cultural References & Intersectionality

The concept of culture has been the subject of many different scientific discourses. The research approaches go back to the cultural anthropologist Malinowski, the pioneer of ethnographic field research (1932). The cultural anthropologists Kroeber and Kluckhohn (1952) provide a comprehensive overview of the multitude of definitions and at the same time refer to the dynamic concept of culture, whose approach is regarded as a 'pattern theory of culture', i.e. culture presupposes development and change. Currently, depending on the discipline, different perspectives are focused with the term 'culture', depending on the scientific paradigms (Hansen, 2000; Bolten, 2007; Moosmüller, 2007; Straub, 2004).

The culture of a given group is predicated on a system of collective knowledge that endows the group with its sense of purpose and identity. Concurrently, it is replete with symbols, signs, and conventions, the acquisition of which occurs during the process of socialization. However, these symbols, signs, and conventions are not fixed; rather, they can be interpreted and lived flexibly by individuals (Marchwacka, 2021). Consequently, culture cannot be static and nor does it lend itself to complete agreement on a cultural system of norms, as culture is not homogeneous. Rather, it is characterized by contradictions and overlaps across diverse dimensions (age, language, educational status, ethnicity, occupation, etc.). The intercultural overlap between the self and the other, or "Otherness," as conceptualized by Bennett (2016) and Bennett (2004), is evident in nearly all aspects of healthcare and social care within multicultural society. The visible aspects, such as language skills and eating habits, are primarily perceived in everyday life, while the underlying values, norms, and justifications remain mostly hidden. In the context of cultural sensitization, these underlying aspects require explicit examination with the other person and their perspective. The invisible aspects pose the greatest challenge for adequate communication and for building relationships as a basis for working in healthcare (Fig. 7).

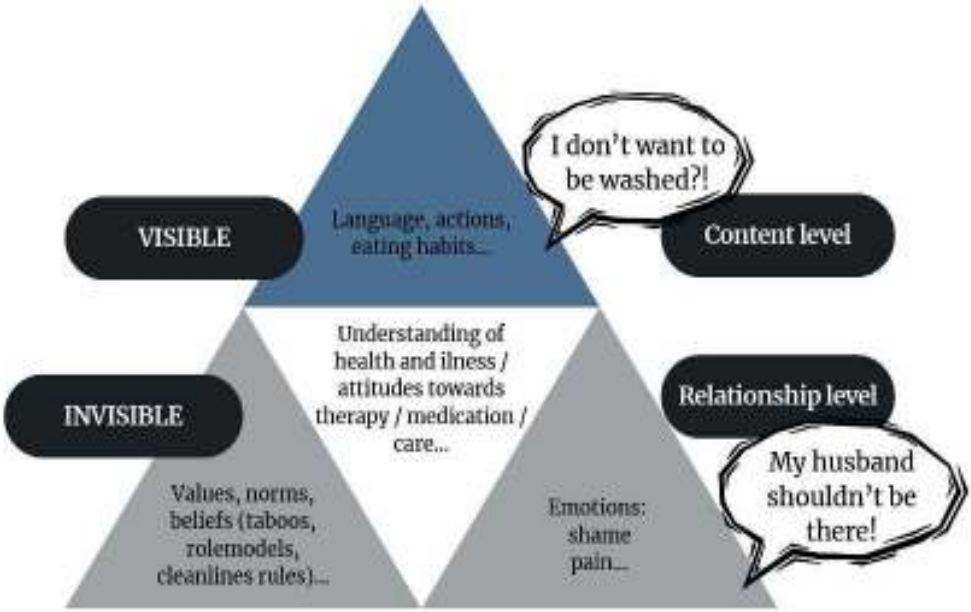


Fig 7. Cultural aspects and levels of reflection (Marchwacka, 2021, 2022)

These interactions can give rise to misunderstandings, feelings of insecurity, and, on occasion, frustration due to unanticipated reactions, beliefs, and value systems, as individuals from different cultural orientations may face a lack of understanding and insecurity when confronted with perspectives that diverge from their own.

The interweaving of self and other (otherness) as well as the diversity of the individual's cultural references suggest that a different differentiation is made depending on the interaction partner and that no homogeneous and unambiguous boundary can be drawn. Gender, resources, age, and subcultures reveal the crossovers within an ethnic group or linguistic culture. To illustrate this point, consider a hypothetical oncology ward. The ward might treat an elderly patient whose native language is Turkish and who frequently receives visits from her family, as well as a single Russian-speaking businesswoman who, despite her socio-cultural resources, might lack the support of family members due to their international residences. The final patient might be a minor from Afghanistan with only a basic understanding of local language. Patients' life experiences suggest different socialization processes and resources, despite their migration experiences and membership in the arbitrarily constructed group of "migrants." In addition, the individuals experience different opportunities for participation and, in some cases, mechanisms of distinction. Notably, language barriers due to insufficient German proficiency can impede communication, leading to a sense of speechlessness and, consequently, psychological distress (Kürsat-Ahlers, 2000). This phenomenon persists even among individuals with higher levels of education, underscoring the challenges posed by linguistic differences in communication. This predicament often engenders feelings of dissat-

isfaction, as well as a sense of powerlessness in the face of the inability to articulate and meet the linguistic expectations. It is noteworthy that specialists from foreign countries frequently encounter this phenomenon. This is due to their comparatively poorer command of German, resulting in their specialist knowledge—particularly in areas such as anamnesis and counseling—falling short of effective articulation and, consequently, being underperceived.

The "axes of difference" (Knapp, 2008) can be categorized as either vertical (German/non-German) or "transverse" (heterosexual/homosexual). These axes can generate third effects through shifts and distortions, resulting in the emergence of "inbetween spaces" (Dietze, 2008). To illustrate this phenomenon, we can consider the example of a Turkish doctor facing discrimination in both the social sphere and his or her professional life (due to language and culture). However, the doctor may simultaneously overlook everyday experiences involving mechanisms of distinction, such as socio-economic status (doctor), gender, and educational status (academic), within his or her own social and economic milieu.

Conversely, adopting an intersectional perspective as "integral" thinking (Walgenbach, 2007) has the potential to facilitate productive self-criticism of hegemony (Dietze, 2008,) and enable the consideration of individuals as composite entities comprising various fields of power-based or marginalizing difference (Grewal & Kaplan, 1994). It is imperative to recognize that intersectional categories should not be construed as an inherent essence, but rather as context-dependent categories that are susceptible to variation across temporal and geographical boundaries (Dietze 2008).

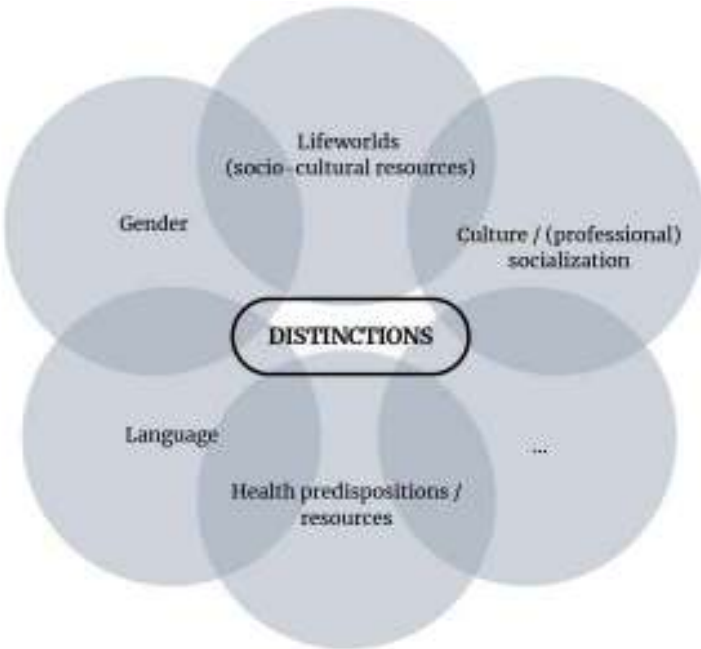


Fig 8. Diversity and Interdependencies (own design based on Mecheril & Seukwa, 2006; Bourdieu, 1982)

In summary, encounters in health and healthcare provision with diverse affiliations and cultural diversity are to be regarded as learning and educational processes within professional settings. Interactions in professional settings occur in different roles (e.g., physiotherapist, therapist, patient, client) and are embedded within social structures (e.g., clinics, rehabilitation centers) and constrained by power structures, hierarchies, and economic constraints. The processes by which these different factors are negotiated can and should be incorporated into the training provided to healthcare and social service workers and professionals. Intercultural learning is an essential component of professional training, particularly with regard to patient orientation and patient safety. In this context, encounters that facilitate intersectional understanding can be considered groundbreaking, as they reveal communication problems that can contribute to introspection regarding one's own identity and role, as well as to the institution's capacity to evolve as a learning organization. In addressing these challenges, it is essential to foster intercultural competence at the individual level alongside diversity management at the structural level, replacing the monocultural orientation that has traditionally characterized healthcare facilities.

The central point that should be elaborated is that the concept of cultural diversity in healthcare is not static; rather, it is shaped by a variety of dynamic and intersecting factors, such as language and socialization. It is important to note that effective intercultural communication requires awareness of both visible and invisible cultural elements, as this fosters patient-centered care. Distinctions within intersectionality—such as socio-economic status, gender, and ethnicity—influence power dynamics and opportunities for participation in healthcare. It is essential to incorporate intercultural learning and diversity management into professional training to enhance patient safety and institutional adaptability.

5.3. Cultural Diversity: Example Germany

The cultural diversity of the population is characterized by coexisting with a multitude of languages, religions and beliefs, which are exemplified by immigration countries such as Germany, thereby highlighting their multiculturalism (cultural diversity). The reasons for immigration vary, including economic, political and familial motives, as well as differing levels of resources. In migration research, the concept of 'push and pull factors' is frequently discussed (Bade & Oltmer, 2004). **Push factors** include, but are not limited to, wars, poverty, hunger, and inadequate healthcare systems. Conversely, **pull factors** are associated with the promise of a better future, opportunities for advancement, and access to education.

A significant area of study in educational sciences is that of biographical educational trajectories and equal opportunities within education systems. This field focuses on inequities in educational opportunities, power structures, and (institutional) discrimination, uncovering these critical issues (Gogolin, 2019; Toprak & Weitzel, 2017). The result, calls for equity in education, diversity management and

intercultural competence (cultural understanding and adaptability) are not limited to education systems but extend to all structures of a migration society that recognizes diversity and values inclusion. According to the microcensus, 70% of people living in Germany have no migration background, while 30 % do, of which 10% are foreigners without German citizenship (Statistisches Bundesamt, 2023). A similar trend is observed among children under five years of age, with the proportion reaching around 40%. The healthcare sector in Germany is experiencing a continuous influx of foreign professionals, with the share of workers with a migration background estimated at 15% in healthcare professions. The largest proportion of these professionals is in the field of elderly care, accounting for 30% (Sachverständigeratfür Integration und Migration, 2022).

In healthcare statistics, the group "migrants" is either understood as a homogeneous group or differentiated according to the two categories "non-Germans" and "persons with a migration background" (RKI). While this categorization is important, it should be approached with sensitivity and viewed critically, as it entails the risk of dichotomization (binary thinking) "we" (Germans) versus "the others" ("migrants"). The construction of an ethnic group and its perceived particularities is often substantiated and intensified by statistical findings, and health risk factors such as addictive behavior (e.g. alcohol consumption) or obesity are recorded according to ethnicity (e.g. "Russian" or "Turkish" young people). However, data are rarely differentiated by factors such as migration duration, socio-economic resources, or other variables (e.g., language and gender) (Marchwacka, 2013). Consequently, this form of reporting can result in the construction of homogeneous migrant groups and intensify dichotomization.

The social construction of "people with a migration background" does not reflect a homogeneous phenomenon, as no uniform picture of their lives can be expected. Instead, migration should be conceptualized as a **dynamic process** that varies despite **certain biographical similarities**, including:

- The experience of growing up in ethnic communities (ethnic homogeneity), where individuals derive a sense of security from the unity of the group.
- The experience of growing up in two linguistic cultures: the parents' native language and the German environment. The parents' native language underscores a sense of belonging, which plays a significant role in identity formation.

Furthermore, the recognition of the synergistic effects of cultural diversity in the form of hybrid identities is enabled by growing up in bicultural or trilingual families (Marchwacka, 2022). The course of migration processes can be influenced by linguistic as well as sociocultural and economic resources. For instance, proficiency in English as a native language can serve as a resource, facilitating migration processes. Furthermore, the educational status attained prior to migration to Germany, or that of the parents, can influence individual development and social participation (Marchwacka, 2013). Conversely, skilled workers who possess

a nuanced understanding of German and hold good educational qualifications, yet lack family, school or studyrelated networks, may encounter limitations in their social integration, potentially leading to feelings of isolation. Furthermore, foreign skilled workers encounter barriers to adequate recognition of their qualifications (Döring, 2019; Best, et al. 2019), thus facing limits to professional integration. Theoretical and practical qualifications acquired abroad are experiencing a new reality in Germany, e.g. with regard to care and documentation systems, as well as areas of responsibility, competences and working methods. This has been shown to result in confusion and dissatisfaction among team members (Schilgen, et al. 2019).

Migration is not a homogeneous phenomenon; it is a dynamic process influenced by linguistic, socio-cultural, and economic factors. These factors shape individual experiences and professional integration.

It is therefore recommended that the term "migrants" be considered as a heterogeneous group, with attention given to individual developmental potential, resources, and migration processes that influence socialization, including professional socialization. In light of the increasingly diverse migration processes and the rising number of patients, clients, and residents with migrant backgrounds, healthcare and care providers face the challenge of addressing diversity among trainees, professionals, patients, and clients (Schilgen, et al., 2019).

This should be approached in the spirit of an inclusive society and patient-centred care. The discourse should shift from integration, which is often perceived as a deficit, to inclusion, which emphasizes equitable participation and involvement of all individuals irrespective of their opportunities and restrictions, gender roles, linguistic-cultural and ethnic backgrounds, social milieus, sexual orientations, or political-religious convictions (Hinz, 2015).

Healthcare and education systems must shift from an integration perspective—often perceived as a deficit—to an inclusion-oriented approach. This approach ensures equitable participation and values diversity in all its forms.

5.4. Intercultural Education as a Process of Interaction

Interculturality is defined as a process of interaction that arises through cultural contact, with the process character of the interaction situation defined as "interculture" (process "in between") (Bolten, 2007). Within the domain of health and nursing education, "interculture" can be conceptualized as a multifaceted learning process that encompasses the acquisition of skills and the cultivation of a disposition to comprehend and be comprehended by others, to nurture relationships characterized by mutual recognition and appreciation, to interact in a manner that is patient-oriented and communicative, and to manage conflicts through argumentative means. The understanding of intercultural dynamics should serve as the foundational principle of communicative behaviour.

These aspects include the ability to:

- recognize the intention of an individual,
- grasp the meaning,
- capture a meaning within a context,
- comprehend a foreign language,
- identify causes and recognize the phenomenon, and
- develop an understanding of people and their situation (Heringer, 2004).

Treating and caring for people with their individual needs and in their special role as patients requires an understanding in the hermeneutic sense (the art of interpretation according to Gadamer 1972). In this context, language as a medium of communication remains the focus of understanding. Intercultural learning implies both language (foreign language: this encompasses not only verbal communication, such as German, English, Italian, and other languages), but also non-verbal and paraverbal elements, which can pose challenges, particularly in the context of interpersonal relationships. For instance, the manner in which a conversation commences, such as the pronunciation of names or the use of dialects, can significantly influence the development of a positive relationship or lead to irritation. Furthermore, the nature of interactions is influenced by various factors, including, but not limited to the patient or client's age, language skills, the specific circumstances of care or treatment, and the context of the interaction (e.g., hospital or rehabilitation center). These factors play a crucial role in the development and maintenance of communication and relationships, which are of paramount importance in intercultural contexts involving healthcare provision.

Auernheimer (2003, 2008) identifies four key factors influencing intercultural communication:

- power asymmetry,
- collective experiences,
- self- and external perception, and
- cultural patterns.

Power asymmetry: Patients encounter roles assigned to them as respondents in communicative action (during treatment, intervention, or the care process), which curtails autonomy and simultaneously highlights the power imbalance. The evident power imbalance hinders engagement, further compounded by a lack of comprehension of the health system or the language.

Collective experiences: Patients' attitudes and expectations regarding care, doctors, and other health professionals are influenced by their personal experiences as well as those of their family members, and friends.

Self-perception and the perception of others: Selective perception of others in specific circumstances can give rise to cultural essentialism and generalizations. Within the clinical context, patients' perceptions of nursing staff and doctors are influenced by fears, concerns, and resignation, leading to the generalization of individual experiences (e.g., perceived lack of time for questions, constrained communication, hurried interactions) (The nursing staff take little time, do not listen). The involvement and associated emotions can also impact the relationship between the patient and health professional, as well as on interprofessional team building.

Difference in cultural patterns: Cultural patterns are shaped by shared experiences rather than national backgrounds, influenced by attitudes towards life, socio-cultural contexts, the language used. Consequently, cultural patterns are considered socially constructed, shaped by the personal experiences of individuals in everyday life and at work. These patterns can be classified into various milieus (Nohl, 2013), which can lead to experiences of strangeness or difference. The process of creating "otherness" (Bennett & Bennett, 2004): "They are...," "That is typical for...," characterizes a form of (constructed) cultural specificity that has the potential to result in communication difficulties.

In summary, the critical elements for communication processes or communication disorders (Fig. 9) include the use of language, forms of communication, biographical experiences, and cultural affiliation. These elements are central to intercultural situations.

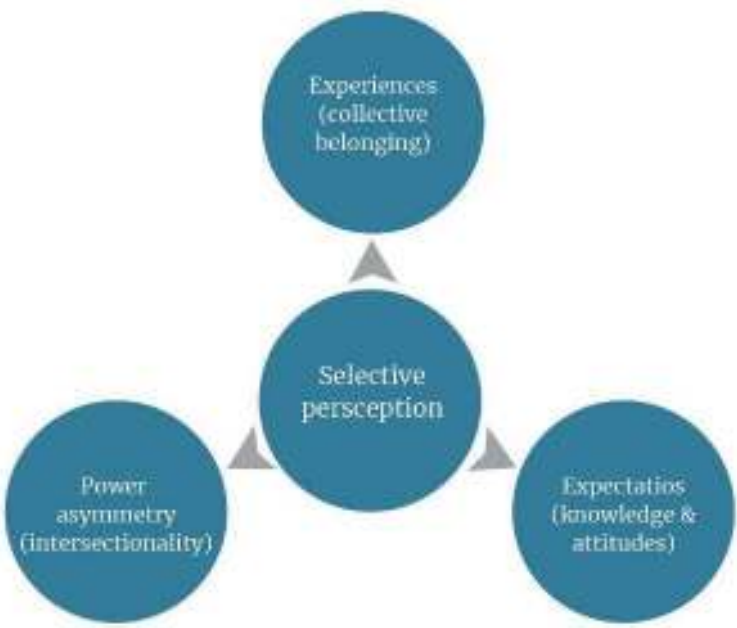


Fig. 9. "I-/We vs. Other" Construction and Social Perception

In the context of professional interactions, the disruption of communication between healthcare professionals and patients/clients, as well as among the healthcare professionals themselves, gives rise to irritations and misunderstandings. When these irritations and misunderstandings are consciously perceived, they have the potential to serve as catalysts for a learning process within the professional setting. In the learning process, subjective perceptions and experiences of difference, as well as mutual expectations and the effects of one's own language, can be reflected upon. This can be achieved through feedback-oriented scenarios that take into account the perspective of the patient and in an interprofessional setting. Learning scenarios can be implemented in various settings, including education, training, continuing education, school, and the workplace. These scenarios contribute to professional development with the aim of patient safety and patient orientation. A key prerequisite for this is structured feedback and self-reflection, which ultimately contribute to intercultural competence.

In the field of healthcare, intercultural learning encompasses more than mere comprehension of disparate cultural frameworks — it involves genuine interactions, effective communication, and the establishment of trusting relationships with patients and colleagues. By acknowledging power dynamics, cultural perspectives, and communication challenges, individuals can cultivate essential competencies to deliver patient-centered care and effectively collaborate within diverse teams.

5.5. The Development of Reflective Competence

Referring to Erpenbeck and Sauter's (2000)and Wagner and Sauter`s (2017) concept of competence and understanding of competence as self-organization dispositions, intercultural competence (cultural understanding and adaptability) can be seen as a disposition to use skills and abilities (combined with motivation and will) appropriately in intercultural situations. Allemann Ghionda (2009) emphasizes that intercultural competence (cultural understanding and adaptability) should enable individuals to react in situations of cultural contact or conflict not with incomprehension, irritation, and misconduct. However, effective communication is characterized by understanding, tolerance of ambiguity, and the will to communicate and behave in a comprehensible manner. In essence, effective communication requires a deliberate and reflective learning process (Forster 2014, Geier 2016) that contributes to personal development. Reflexive competence is essential for fostering intercultural understanding in healthcare settings. This competence goes beyond technical skills by encouraging individuals to critically evaluate their actions, beliefs, and interactions within a cultural context (Moosmüller, 2020). For example, healthcare providers must reflect on how their own cultural backgrounds and professional training influence their perceptions and treatment approaches. This competence is integral to building trust, ensuring equitable care, and navigating complex cultural dynamics in clinical and educational settings.

In accordance with the models of intercultural competence by Campinha-Bacote (2002) and Moosmüller (2020), the following elements can be distinguished to characterize intercultural situations (Fig. 10).

- Cultural imprint: awareness of one's own world of experience and cultural imprint in the course of education and socialization and the resulting behavior, routines/habits.
- Ego-otherness construction (change of perspective): perception of the other and the effect of one's own language, communication, and behavior on interaction partners; both empathy and ambivalence of emotions should be consciously perceived here.
- Action strategies at the personal level: potential courses of action in the context of the negotiation process and reflection on one's own role and attitude.
- Action strategies in an intersectional understanding: potential courses of action in the context of the negotiation processes with a focus on existing power structures and their analysis.

Fig. 10. Reflective intercultural competence (Marchwacka 2017, 2022)

Intercultural competence, therefore, must be understood as an ongoing process of reflection that is integral to learning. It is characterized by the ability to consider one's own experiences, diverse interpretations of situations, and encounters with power relations, which require time and space to adequately unpack. The learning process focuses on achieving two main objectives. First, there is the development of a reflective awareness of one's own cultural and linguistic socialization, which refers to one's sense of collective affiliation. Second, there is the exploration and analysis of one's impact on others through the change/shift of perspective. In order to achieve this objective, it is essential to consciously acknowledge the presence of empathy and the ambivalence of emotions. The overarching goal is twofold: first, to introspectively examine one's own role and the prevailing structures within the context of intercultural scenarios; and second, to methodically analyze potential actions that are influenced by emotions and ambivalence.

The acquisition of intercultural competence (cultural understanding and adaptability) is to be regarded as a lifelong learning process that necessitates time and space for reflection on experiences, interpretations of situations, and encounters with power relations. The learning process emphasizes:

- Reflective awareness of one's own cultural-linguistic socialization (collective affiliations).
- Exploration and analysis of one's effect on others through perspective shifts.

Recognition of empathy and the ambivalence of emotions. The overarching objective of this process is twofold: firstly, to reflect on one's role and existing structures in intercultural situations, and secondly, to analyze possibilities for action associated with emotions and ambivalence.

The acquisition of intercultural competence, which encompasses cultural understanding and adaptability, should be conceptualized as a lifelong learning process requiring dedicated time and space for reflection on one's own experiences, varied interpretations of situations, and engagement with power relations. The learning process is focused on two key aspects: first, the introspective examination of one's own cultural and linguistic socialization, encompassing collective affiliations; and second, the exploration and analysis of one's own impact on others through the perspective shift. Empathy and the ambivalence of emotions must be consciously recognized. The objective is twofold: first, to introspectively examine one's role and prevailing structures within the context of intercultural scenarios; and second, to methodically analyse the potential for action, considering the emotional nuances and ambivalence inherent in these situations. Intercultural learning is conceptualized as a form of social learning, emphasizing the principles of dialogue and the autonomy of individuals within social structures. This approach places the subjects at the center, recognizing their capacity to act and make decisions. In this regard, learning and educational processes are dynamic and occur within the context of communication and interactions that are embedded in the social environment.

The learning process is centered on managing differences and power structures, as well as negotiation processes, with a focus on acquiring key competencies for

effective action. The negotiation processes require interactants to tolerate frustration and ambiguity in order to endure differences and to adhere to the principle of dialogue in terms of argumentation. They also require the ability to deal with conflict and cooperation, as decision-making within power structures implies conflicts. The possible strategies are generated in joint discourse and through (self-) reflection and insight. The focus is on acquiring skills in open and complex situations in the sense of self-organization skills according to Erpenbeck and Sauer (2000). Authentic (interculturally characterized) professional situations represent the starting point for knowledge-oriented learning processes.

Intercultural competence is defined as a comprehensive set of skills and attributes that enable an individual to effectively navigate and communicate in diverse cultural contexts. It encompasses more than mere knowledge; rather, it is a continuous, lifelong learning process that demands reflection, empathy, and adaptability. In engaging with diverse cultural perspectives, it is essential to allocate time for introspection, contemplating one's personal experiences and the impact of one's actions on interactions with others. The cultivation of intercultural competence is predicated on the principles of dialogue, selfawareness, and the willingness to navigate complexity with an open mind.

5.6. Let's Change Our Perspective and Move Away From Essentialism

In a world characterized by cultural diversity, navigating differences can be both a challenge and an opportunity. Language barriers, cultural misunderstandings, and hidden institutional biases may appear daunting at first. However, they also represent powerful moments for growth and learning. Imagine encountering a patient whose cultural background or worldview differs significantly from your own—how would you bridge that gap? How can you ensure that everyone feels seen, respected, and valued? Such situations demand more than technical expertise; they require reflexive competence, empathy, and the courage to challenge one's own assumptions. By embracing these challenges, one is not only overcoming barriers but actively shaping a more inclusive and equitable future. Developing reflexive competence allows for the transformation of misunderstandings into meaningful connections, the building of trust, and the creation of solutions that benefit all parties. Each obstacle thus becomes an opportunity for personal and professional growth.

Critical Incident

The critical incident technique was first introduced by Flanagan in 1954 and subsequently revised in 1963. This technique is predicated on critical professional situations, characterized by moments of tension and irritation. The targeted analysis and processing of these situations has been demonstrated to facilitate the devel-

opment of reflective competence. This approach is currently employed in various contexts, including but not limited to:

- as a qualitative research method,
- for error management,
- in university didactics (Marchwacka, et al., 2021).

The method can be understood as the direct observation of an individual's behavior in a specific critical situation, an event with various potential causes, and that is analyzed throughout the learning process to promote understanding of such critical situations. Among the various factors that contribute to such misunderstandings are "rich points" (Agar, 1994), which are also known as stumbling blocks, arising from cultural idiosyncrasies in communication. These elements have the potential to impede effective linguistic analysis. Misunderstandings can emerge, for instance, from the divergent approaches to the utilization of formal and informal forms of address, the volume employed in communication, or the employment of titles.

Learning processes that are based on critical incidents, which are influenced by culture-related behavior, communication (Marchwacka, et al., 2021, 2022), and which analyze intercultural interactions while taking affective levels into account, have the capacity to shift one's perspective from the self to the other. This shift in perspective can be accompanied by a process of self-reflection, characterized by the questioning of personal convictions and habitual responses. It can also give rise to feelings of frustration and ambiguity. These emotions, stemming from feelings of frustration and ambiguity, can serve as the catalyst for the initiation of the learning process, propelled by involvement in both one's own emotions and those of others. A multi-perspective view of the situation has also been shown to enable distance not only from one's own role, but also from the role of the patient. In turn, this enables a reflective attitude (rather than essentialism) towards different cultural and linguistic affiliations, which can help improve patient safety on the one hand and increase opportunities for participation in the healthcare system on the other.

Critical incident analysis serves as a practical tool for developing reflexive competence. By examining specific situations where cultural misunderstandings arise, professionals can identify underlying assumptions, biases, and areas for growth. This reflective process transforms challenging encounters into valuable learning opportunities.

Critical incidents offer the opportunity to consciously experience cultural ties and to reflect on the role played and its effect on the meta-level. Concomitantly, by

The application of critical incident analysis in professional settings has been shown to encourage professionals to engage in perspective-taking rather than relying on essentialist views of culture. This process of self-reflection has been demonstrated to promote self-awareness and intercultural competence by fostering an understanding of diverse viewpoints. By analyzing challenging scenarios, individuals develop strategies to navigate professional interactions with greater adaptability and openness.

adopting other perspectives, individuals gain critical distance from themselves and their respective cultural affiliation—a learning process that promotes the interpretation and revision of their own perspective.

These critical interaction situations function as opportunities for the analysis of cultural affiliations and the development of interpretative and discursive strategies for action. Ultimately, these strategies are intended to shape professional situations in a self-directed and competent manner.

5.7. Conclusion

In summary, it should be emphasized that culture and nation/society are not congruent. Within a society, different cultures coexist and are interlinked, so people can usually belong not only to one culture but to several. This allows them to exercise agency, enabling them to "switch" and follow the norms of other cultures (e.g., linguistic and professional) in order to act appropriately in a given situation. This ability can be seen as the result of learning processes. Consequently, the crossing and intersectionality of cultures should be regarded as the norm, given that every cultural attribution exhibits interdependencies. Depending on the dimension of differentiation, we construct cultural images of "women," "midwives," "persons with migration experience," "Germans," and "addicts." Depending on the context and interaction partners, we also adjust the language and forms of communication, as evidenced by the use of professional language by an emergency paramedic when working with a female colleague, the use of technical language in an academic context during a conference in therapy sciences, the use of patient language with female patients/clients, and the use of interprofessional team language (Marchwacka 2019, Skintey & Marchwacka 2022). Consequently, this phenomenon can be understood through the lens of identity formation, influenced by factors such as profession, society, ethnicity, and belonging processes. However, it is important to note that these interactions can also lead to the establishment of boundaries, as demarcations become apparent when misunderstandings arise. In healthcare settings, these misunderstandings necessitate action to ensure adequate treatment, underscoring the importance of reflective competence in professional interactions.

Reflexive competence and cultural awareness are essential for addressing the challenges posed by a diverse society, particularly in healthcare. These competencies can transform one's approach to professional excellence. By critically reflecting on one's perspectives and understanding cultural differences, individuals can overcome barriers and contribute to more inclusive and equitable practices.

Developing reflexive competence:
- *Critical Incident and case analysis (select incident – research information)*
- *Perspective shift (swap roles & explore alternative actions)*
- *Reflection (discuss emotion, provide feedback, write portfolio)*

Ensuring the integration of reflexive intercultural competence—defined as Cultural Understanding and Adaptability—is imperative to ensure patient safety and effective patient orientation. It is crucial to acknowledge this as a lifelong learning process that transcends professional boundaries, necessitating its incorporation into the educational framework of healthcare professions and interprofessional education. In this regard, there is a necessity to develop and evaluate teaching and learning arrangements in a manner that is aligned with the needs and demands of the situation. A particularly efficacious approach to fortifying reflexive intercultural competence is through the utilization of critical incidents. These structured, real-life scenarios allow healthcare students to engage with intercultural challenges within a supportive learning environment. The analysis and reflection on these scenarios foster the development of essential competencies in professional, culturally competent patient care, enhancing students' clinical decision-making skills and their capacity to navigate diverse healthcare settings with sensitivity and confidence.

Reflection is pivotal for developing intercultural competence in healthcare, enabling healthcare professionals to navigate diverse settings adeptly and flexibly. Through critical reflection, students can enhance patient-centered care and cultivate effective interprofessional collaboration.

References

Agar, M. (1994). *Language shock: Understanding the culture of conversation*. William Morrow & Co.

Auernheimer, G. (2003). *Einführung in die interkulturelle Pädagogik* (3. Aufl.). Darmstadt.

Auernheimer, G. (Hrsg.). (2008). *Interkulturelle Kompetenz und pädagogische Professionalität*. Springer.

Bade, K. J., & Oltmer, J. (2004). *Normalfall Migration. Bundeszentrale für politische Bildung*.

Bennett, J. (1993). Cultural marginality: Identity issues in intercultural training. In R. M. Paige (Ed.), *Education for the intercultural experience* (pp. 109-135). Intercultural Press.

Bennett, J. M., & Bennett, M. J. (2004). Developing intercultural sensitivity: An integrative approach to global and domestic diversity. In D. Landis, J. M. Bennett, & M. J. Bennett (Eds.), *Handbook of intercultural training* (pp. 147-165). Sage.

Best, U., Erbe, J., Schmitz, N., Arnold, S., Koch, R., Mundt, S., & Rausch-Berhie, F. (2019). *Berufliche Anerkennung im Einwanderungsprozess – Stand und Herausforderungen bei der Antragstellung aus dem Ausland*. Ergebnisse des BIBB-Anerkennungsmonitorings. BIBB.

Bolten, J. (2007). Was heißt "Interkulturelle Kompetenz?" Perspektiven für die internationale Personalentwicklung. In V. Künzer & J. Berninghausen (Eds.), *Wirtschaft als interkulturelle Herausforderung* (pp. 21-42). Frankfurt/M.

Bourdieu, P. (1982). *Die feinen Unterschiede*. Suhrkamp.

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of Transcultural Nursing*, 13(3), 181-184. https://doi.org/10.1177/10459602013003003

Dietze, G. (2008). Intersektionalität und Hegemonie(selbst)kritik. In W. Gippert, P. Götte, & E. Kleinau (Eds.), *Transkulturalität - Gender - und bildungshistorische Perspektiven* (pp. 27-43). Transcript.

Döring, O. (2019). Erkennung und Anerkennung informell und non-formal erworbener Kompetenzen: Einstieg in eine breite Nutzung fragmentierter Beschäftigungsfähigkeit. In J. Seifried, B.-J. Ertelt, A. Frey, & K. Beck (Hrsg.), *Beruf, Beruflichkeit, Employability* (pp. 137-159). Wbv.

Erpenbeck, J., & Sauer, J. (2000). Das Forschungs- und Entwicklungsprogramm "Lernkultur Kompetenzentwicklung." In Arbeitsgemeinschaft-Qualifikations- und Entwicklungsmanagement (Eds.), *Kompetenzentwicklung 2000. Lernen im Wandel – Wandel durch Lernen* (pp. 289-335). Waxmann.

Flanagan, J. C. (1954). The critical incident technique. *Psychological Bulletin*, 51, 327-358.

Flanagan, J. C., Gosnell, D., & Fivars, G. (1963). Evaluating student performance. *The American Journal of Nursing*, 63(11), 96-99.

Forster, E. (2014). Reflexivität. In C. Wulf & J. Zirfas (Eds.), *Handbuch Pädagogische Anthropologie* (pp. 589-597). Springer.

Gadamer, H.-G. (1972). *Wahrheit und Methode: Grundzüge einer philosophischen Hermeneutik*. Mohr.

Geier, T. (2016). Reflexivität und Fallarbeit. In A. Doğmuş, Y. Karakaşoğlu, & P. Mecheril (Eds.), *Pädagogisches Können in der Migrationsgesellschaft*. Springer. https://doi.org/10.1007/978-3-658-07296-4_10

Gogolin, I. (2019). Lernende mit Migrationshintergrund im deutschen Schulsystem und ihre Förderung. *Journal for Educational Research Online*, 11(1), 74–91. http://nbnresolving. de/urn:nbn:de:0111-pedocs-16788

Grewal, I., & Kaplan, C. (Eds.). (1994). *Scattered hegemonies: Postmodernity and transnational feminist practices*. University of Minnesota Press.

Hansen, K. (2000). *Kultur und Kulturwissenschaft*. Francke.

Heringer, H. J. (2004). *Interkulturelle Kommunikation*. UTB.

Hinz, A. (2015). Inklusion - mehr als nur ein neues Wort?! In Heinrich-Böll-Stiftung (Eds.), *Inklusion* (pp. 286–291). Campus.

Knapp, G. A. (2008). Achsen der Differenz — Aspekte und Perspektiven feministischer Grundlagenkritik. In S. M. Wilz (Eds.), *Geschlechterdifferenzen — Geschlechterdifferenzierungen* (pp. 291–322). VS. https://doi.org/10.1007/978-3-531-90831-1_10

Kroeber, A. L., & Kluckhohn, C. (1952). *Culture: A critical review of concepts and definitions.* Boni & Liveright.

Kürsat-Ahlers, E. (2000). *Migration-Frauen-Gesundheit*. In M. David, Th. Borde, & H. Kentenich (Eds.), Migration und Gesundheit (pp. 45–56). Mabuse.

Malinowski, B. (1932). *Argonauts of the Western Pacific*. https://wolnelektury.pl/media/book/pdf/argonauts-of-the-western-pacific.pdf

Marchwacka, M. A. (2013). Zu Risiko- und Schutzfaktoren in den Lebenswelten von Jugendlichen mit Zuwanderungsgeschichte. In M. A. Marchwacka (Eds.), *Gesundheitsförderung im Setting Schule* (pp. 301–326). Springer.

Marchwacka, M. A. (2021). Interkulturelles Lernen als inhärenter Teil der Gesundheits- und Pflegebildung. In F. Darmann Fink & K. H. Sahmel (Eds.), *Pädagogik im Gesundheitswesen*. Springer. https://doi.org/10.1007/978-3-662-61428-0_23-1

Moosmüller, A. (Ed.) (2020). *Interkulturelle Kompetenz. Kritische Perspektiven*. Waxmann.

Sachverständigenrat für Integration und Migration. (2022). *Systemrelevant: Der Beitrag von Zugewanderten im Gesundheitswesen*.

Schilgen, B., Handtke, O., Nienhaus, A., & Mösko, M. (2019). Work-related barriers and resources of migrant and autochthonous homecare nurses in Germany: A qualitative comparative study. *Applied Nursing Research*, 46, 57–66. https://doi.org/10.1016/j.apnr.2019.02.008

Statistisches Bundesamt. (2023). *Migration und Integration: Bevölkerung mit Migrationshintergrund*.

Toprak, A., & Weitzel, G. (2017). *Deutschland das Einwanderungsland*. Springer

Walter, A., Dütthorn, N., Brühe, R., Marchwacka, M. A., & von Gahlen Hoops, W. (2022). Ein digitales hochschulübergreifendes Projekt zur Fallarbeit. In M. A. Marchwacka (Ed.), *Handbuch Pflege* (S. 236–244). Hogrefe.

Wagner, M. H., & Sauter, W. (2017). Interkulturelle Kompetenzentwicklung im Prozess der Arbeit und im Netz. In J. Erpenbeck & W. Sauter (Eds.), *Handbuch Kompetenzentwicklung im Netz – Bausteine einer neuen Lernwelt* (507–522). Schäffer-Poeschel.

Final Reflection: Reflexive Competence as a Realization of the EMPOWER Model

by Małgorzata Szkup

Rozdział *Tożsamość kulturowa a opieka zdrowotna* ukazuje, w jak znaczący sposób tożsamość kulturowa kształtuje postrzeganie zdrowia, choroby oraz relacji jednostki z systemem ochrony zdrowia. Tym samym wprost wspiera kluczowe założenia modelu EMPOWER, który koncentruje się na: efektywności, wielokulturowości, profesjonalizmie, dobrostanie i zasobach edukacyjnych.

Autor rozdziału podkreśla wagę traktowania pacjenta jako podmiotu, a nie przedmiotu opieki – co doskonale wpisuje się w wartości EMPOWER, takie jak autonomia pacjenta, relacje oparte na partnerstwie oraz empatyczne podejście skoncentrowane na godności człowieka. Poprzez analizę błędów poznawczych i atrybucyjnych – takich jak projekcja, fundamentalny błąd atrybucji czy fałszywa zgodność – rozdział dostarcza praktycznych narzędzi do rozwijania pokory kulturowej i świadomości własnych uprzedzeń, które są niezbędne dla wrażliwości międzykulturowej w kontekście klinicznym.

Poruszenie zagadnień związanych z tożsamością płciową oraz potrzebami zdrowotnymi osób transpłciowych i niebinarnych wzmacnia komponent EMPOWER dotyczący dobrostanu i inkluzywności – pokazując, że tworzenie bezpiecznego, pełnego szacunku i afirmującego środowiska jest nie tylko imperatywem etycznym, lecz także warunkiem skutecznej opieki i efektywnego procesu edukacyjnego.

Rozdział akcentuje również znaczenie autorefleksji i ciągłego uczenia się, zachęcając pracowników ochrony zdrowia do krytycznej analizy własnych postaw i zachowań. Odnosi się to bezpośrednio do filaru zasobów edukacyjnych modelu EMPOWER, który promuje rozwój kompetencji kulturowych i komunikacyjnych w oparciu o doświadczenia życiowe oraz otwartość na zmiany.

Wreszcie, omówienie globalnych wyzwań, takich jak migracje, bariery komunikacyjne i nierówności systemowe, silnie nawiązuje do komponentu efektywności w modelu EMPOWER. Rozdział pokazuje, że dostosowanie usług zdrowotnych do uwarunkowań kulturowych i społecznych przyczynia się do lepszych efektów terapeutycznych i budowania zaufania pomiędzy pacjentami a zespołami medycznymi.

Podsumowując, rozdział ten stanowi przykład tego, jak integracja tożsamości kulturowej z praktyką medyczną może przyczynić się nie tylko do pogłębienia teorii, ale przede wszystkim do działań praktycznych – zachęcając do wdrażania modelu EMPOWER jako narzędzia służącego promocji godności, równości i skuteczności we współczesnej ochronie zdrowia.

Multi Culti Med

Chapter 6

Refugees, Migration and Health

ELENA ROUSOU, PANAGIOTA ELLINA, PARASKEVI CHARITOU

Cyprus University of Technology (Cyprus)

Refugees and migrants face unique health challenges that are often compounded by language barriers, cultural differences, financial limitations, and mental health concerns. These populations are at higher risk for physical and mental health issues.

Addressing these challenges requires culturally sensitive healthcare services, policy reform, and targeted mental health support to ensure that refugees and migrants receive the care they need for both physical and psychological well-being.

6.1. Introduction

Migration, whether voluntary or forced, is a significant global phenomenon. The movement of people across borders impacts not only the individuals involved but also the countries they leave and those that receive them. Migration brings about unique challenges, particularly concerning health. Refugees, asylum seekers, and migrants often encounter distinct health risks and barriers to healthcare that can affect their overall well-being. Understanding and addressing these needs are essential for achieving global health equity and improving the health outcomes of these populations. This chapter examines the intersection of migration, refugee health, and the needs of transcultural communities, focusing on the challenges they face in accessing healthcare and the culturally responsive strategies required to improve their health outcomes (Jarvis & Kirmayer, 2023).

Aims

Through this chapter students will enhance their attitudes, knowledge and skills in:

- **Exploring Migration and Health:** Analyze how migration impacts the physical and mental health of individuals and populations.
- **Defining Key Concepts:** Clarify terms like migration, refugees, transcultural health, and global health.
- **Identifying Health Challenges:** Highlight the unique risks and barriers migrants and refugees face in accessing healthcare.
- **Emphasizing Cultural Competence:** Advocate for culturally responsive healthcare to address diverse needs.
- **Promoting Equity and Inclusion:** Support policies and global health initiatives that reduce disparities and improve health outcomes for all.

Learning Outcomes

By the end of this chapter, readers will be able to:

- **Understand Migration and Health Dynamics:** Describe the health impacts of migration and the challenges faced by migrants and refugees.
- **Define Key Terms:** Accurately define migration, refugees, transcultural health, and global health.
- **Identify Barriers:** Recognize the systemic and individual barriers to healthcare access for migrants and refugees.
- **Apply Cultural Competence:** Explain the importance of culturally sensitive care in improving health outcomes for transcultural communities.
- **Advocate for Equity:** Discuss strategies for addressing health disparities through inclusive policies and global health initiatives.

Relevant Definitions and Terms

According to WHO (2021), **Global Health** focuses on the health of populations across countries and emphasizes the interconnections of health across borders.

It tackles health disparities and works toward improving health outcomes worldwide.

Migration refers to the movement of people from one place to another, typically across political or geographical boundaries, with the intention of settling temporarily or permanently in a new location. It can be voluntary or forced and may involve individuals or groups seeking better opportunities, safety, or escaping adverse conditions, such as conflict, economic hardship, or environmental disasters (International Organization for Migration, 2023).

A **refugee** is defined by the United Nations High Commissioner for Refugees (2023), as an individual who has been forced to flee their country of origin due to a well-founded fear of persecution based on factors such as race, religion, nationality, membership in a particular social group, or political opinion. Refugees are unable or unwilling to return to their home country because of the threat to their safety and are often granted international protection in host countries.

Transcultural health refers to the health needs and challenges of individuals and communities from diverse cultural backgrounds. It emphasizes the importance of understanding cultural differences in health practices, beliefs, and needs when providing healthcare services (Spector, 2016).

Transcultural communities are formed by people from various cultural backgrounds who share common experiences, such as migration or residing in multicultural environments. The health needs of these communities are influenced by their distinct cultural contexts, which shape their health behaviors and challenges in accessing care (Spector, 2016).

6.2. The Impact of Migration on Health

Migration influences the health of individuals in several ways. Migrants may face immediate health risks during their journey, including exposure to infectious diseases, physical injury, and trauma. Refugees, in particular, are often exposed to conditions of extreme vulnerability, such as overcrowded refugee camps, poor sanitation, and limited access to healthcare. These factors significantly affect their physical and mental health (World Health Organization [WHO], 2021).

Refugees and migrants often have unique health needs that differ from those of the host population, requiring care that is both effective and culturally sensitive. This care must address the physical and mental health challenges shaped by the migration experience. Additionally, refugees and migrants may encounter significant barriers to accessing healthcare, including language and cultural differences, limited health literacy, experiences of discrimination, and restricted access

Global migration is expected to continue to increase as climate change, conflict and economic disparities continue to challenge peoples' lives. (Jarvis & Kirmayer, 2023)

to mainstream health services. These challenges can influence their interactions with the host country's healthcare system and workforce, underscoring the need for tailored and inclusive healthcare approaches (World Health Organization [WHO], 2021).

Upon arrival in host countries, refugees and migrants may experience a range of health challenges, including untreated chronic conditions, infectious diseases, and mental health issues such as anxiety, depression, and post-traumatic stress disorder (PTSD). These health issues are compounded by barriers to accessing healthcare, including language and cultural differences, limited financial resources, and a lack of familiarity with the healthcare system (Kirmayer, et al., 2011).

6.3. Health Barriers for Migrants and Refugees

Language

One of the primary challenges that refugees and migrants face when seeking healthcare is language. Limited proficiency in the host country's language can make it difficult for them to communicate their health concerns, understand medical advice, and navigate the healthcare system. This can lead to misdiagnosis, inadequate treatment, and poor health outcomes (González, 2022).

Health Literacy

Additionally, many migrants and refugees have low levels of health literacy, which further complicates their ability to engage with healthcare services. Health literacy encompasses the ability to understand health information, follow medical instructions, and make informed health decisions. Low health literacy can result from limited education, lack of exposure to healthcare systems, or cultural differences in understanding health concepts (Nutbeam, 2008).

Cultural Differences

Cultural differences play a significant role in healthcare access and delivery. Many refugees and migrants come from diverse cultural backgrounds with different beliefs, practices, and attitudes toward health and illness. Healthcare providers who are unaware of or insensitive to these differences may inadvertently cause discomfort, mistrust, or refusal of care (Vissandjée, et al., 2017).

Discrimination

Moreover, migrants and refugees may experience discrimination within the healthcare system due to their ethnicity, immigration status, or socioeconomic position. Discrimination can exacerbate mental health issues, discourage individuals from seeking care, and contribute to overall feelings of alienation and mistrust of healthcare providers (Jarvis & Kirmayer, 2023).

In many host countries, refugees and migrants may have restricted access to healthcare due to their immigration status. Even if healthcare services are available, financial constraints, such as the inability to afford insurance or out-of-pocket costs, may prevent them from receiving timely care. These barriers often lead to untreated health conditions, which can worsen over time (WHO, 2021).

Mental Health

Mental health is a critical but often overlooked issue among refugee and migrant populations. The traumatic experiences of fleeing war, persecution, or economic hardship, followed by the stress of resettlement in a new country, can take a significant toll on mental health. Refugees are particularly vulnerable to PTSD, depression, and anxiety due to the trauma they experienced during displacement and the challenges of adapting to a new environment (Kirmayer, et al., 2011).

6.4. Integrating Global Health, Migration, Refugees, and Transcultural Needs

The themes of global health, migration, refugee health, and transcultural communities are deeply interconnected. Migrants and refugees often carry the burden of health inequities, which are further compounded by systemic issues such as inadequate healthcare infrastructure and societal discrimination. To address these challenges, a holistic approach is essential—one that recognizes the interplay between individual health outcomes and broader socio-political and economic factors (WHO, 2021).

This integration involves strengthening health systems to be inclusive of diverse populations, promoting policies that protect the rights of migrants and refugees, and fostering cultural competence in healthcare. International collaboration and investment in global health initiatives are critical for building resilient health

systems that can respond to the needs of all, regardless of their origin or status. By embracing these principles, the global health community can move closer to achieving health equity for all (IOM, 2023; Spector, 2016).

Refugees, whether internally displaced or forced to leave their home countries, now exceed 100 million worldwide (UNHCR, 2022).

The health challenges faced by migrants, refugees, and transcultural communities are a microcosm of broader global health issues, reflecting disparities that require immediate attention and sustained action. Addressing these challenges calls for inclusive policies, culturally competent care, and international cooperation. By prioritizing equity and leveraging the strengths of diverse populations, the global community can work toward a healthier and more inclusive world.

References

González, A. (2022). Language barriers in healthcare settings: Addressing the needs of migrant communities. Journal of Global Health, 9(2), 214–221.

International Organization for Migration (IOM). (2023). Migration. International Organization for Migration. https://www.iom.int/migration

Jarvis, G. E., & Kirmayer, L. J. (2023). Global migration: Moral, political and mental health challenges. Transcultural Psychiatry, 60(1), 5–12. https://doi.org/10.1177/13634615231162282

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., & Pottie, K. (2011). Mental health care for immigrants and refugees: A cultural perspective. International Journal of Social Psychiatry, 57(3), 147–157. https://doi.org/10.1177/0020764010390715

Nutbeam, D. (2008). The evolving concept of health literacy. Social Science & Medicine, 67(12), 2072–2078.

Spector, R. E. (2016). Cultural diversity in health and illness (9th ed.). Pearson Education.

United Nations High Commissioner for Refugees (UNHCR). (2023). Refugees. United Nations High Commissioner for Refugees. https://www.unhcr.org/refugees

Vissandjée, B., Simich, L., & Allotey, P. (2017). Cultural competence in health care: A scoping review of the literature. BMC Health Services Research, 17(1), 530. https://doi.org/10.1186/s12913-017-2483-6

World Health Organization. (2021). Global health. World Health Organization. https://www.who.int/health-topics/global-health

World Health Organization. (2021). Refugee and migrant health: Global competency standards for health workers. World Health Organization. https://apps.who.int/iris/handle/10665/346743

Final Reflection: Connecting Migration and Health to the EMPOWER Model

by Małgorzata Szkup

This chapter highlights how the complex realities of refugees and migrants directly intersect with the goals of the **EMPOWER model**—especially in terms of **Multiculturalism, Effectiveness**, and **Wellness**. It emphasizes the importance of **culturally sensitive and trauma-informed care**, aligning with EMPOWER's call for practices that respect diversity and empower patients as active participants in their own care.

By addressing systemic barriers such as language, health literacy, and discrimination, the chapter supports EMPOWER's focus on **eliminating inequality and promoting inclusive, patient-centered care**. The emphasis on mental health and structural challenges also echoes the model's commitment to Wellness, advocating for care that addresses both physical and psychological needs.

Moreover, through its advocacy for inclusive policy and international collaboration, the chapter aligns with EMPOWER's vision of **global professional responsibility** and the ethical imperative to serve all patients with dignity and competence—regardless of origin, status, or identity.

In summary, this chapter reinforces the EMPOWER model's mission by showing that transcultural care is not optional—it is essential to delivering ethical, effective, and compassionate healthcare in a globalized world.

Multi Culti Med

Chapter 7

The impact of climate change and the pandemic on global health

ELENA ROUSOU, PANAGIOTA ELLINA, PARASKEVI CHARITOU

Cyprus University of Technology (Cyprus)

Pandemics and climate change are interconnected crises that threaten global development. The COVID-19 pandemic exposed vulnerabilities in healthcare and economies, while climate change exacerbates issues like food insecurity, displacement, and health disparities. Addressing these challenges requires integrated, sustainable solutions to ensure resilience, equity, and long-term progress.

7.1. Introduction

Global health is a multifaceted discipline that addresses the health of populations across borders, emphasizing equity, collaboration, and the interconnectedness of health determinants. The challenges posed by climate change and pandemics have intensified the global health crisis, disproportionately affecting vulnerable populations, including transcultural communities. These communities, often shaped by migration and cultural diversity, face unique health needs that demand tailored and culturally sensitive responses. This chapter explores the intersection of global health, climate change, pandemics, and the health needs of transcultural communities, focusing on strategies to build equitable and resilient health systems.

Aims

Through this chapter students will enhance their attitudes, knowledge and skills in:

- **Exploring the Impact of Global Crises:** Examine how pandemics and climate change affect global health, with a focus on vulnerable populations.
- **Analyzing Vulnerabilities:** Identify the health risks and systemic barriers faced by transcultural communities, migrants, and refugees during global health crises.
- **Highlighting Interconnections:** Understand the interconnected nature of global health, climate change, and pandemics in shaping health outcomes.
- **Promoting Resilient Health Systems:** Advocate for policies and strategies that strengthen health systems to be inclusive, culturally sensitive, and resilient to future challenges.
- **Supporting Global Collaboration:** Emphasize the role of international cooperation in addressing health inequities and mitigating the impact of climate change and pandemics.

Learning Outcomes

By the end of this chapter, readers will be able to:

- **Understand Key Concepts:** Define and explain pandemics, climate change, and their relevance to global health.
- **Recognize Health Challenges:** Identify the unique health challenges faced by transcultural communities during global crises.
- **Analyze Systems:** Evaluate the vulnerabilities in healthcare systems exposed by pandemics and climate change.
- **Apply Strategies:** Recommend culturally sensitive and inclusive approaches to mitigate health disparities and improve resilience.
- **Advocate for Change:** Discuss the importance of global collaboration and equityfocused policies to address climate and health crises effectively.

Relevant Definitions and Terms

A p**andemic** is an outbreak of an infectious disease that occurs on a global scale, crossing international boundaries and affecting a large number of people. Unlike localized epidemics, pandemics involve widespread transmission, often resulting in significant social, economic, and public health challenges (Centers for Disease Control and Prevention [CDC], 2022).

Climate change refers to long-term shifts in temperatures and weather patterns, primarily caused by human activities, such as burning fossil fuels and deforestation. These changes significantly impact human health by exacerbating existing health problems and creating new challenges. For instance, climate change increases the frequency of extreme weather events, worsens air quality, spreads infectious diseases, and affects food and water security, disproportionately impacting vulnerable populations (World Health Organization [WHO], 2021a).

7.2. Pandemics and Their Global Impact

The COVID-19 pandemic has underscored the vulnerabilities of global health systems and highlighted the critical importance of preparedness, equitable response, and resilience in the face of pandemics. It exposed how fragile healthcare infrastructure can be, especially in marginalized communities, including migrants, refugees, and transcultural populations, who often lack access to adequate healthcare and social support systems (International Organization for Migration [IOM], 2023). These groups are particularly vulnerable due to language barriers, cultural differences, and sometimes discriminatory healthcare practices. As a result, they face significant challenges in accessing prevention and treatment measures during health crises. The lessons learned from COVID-19, alongside previous pandemics like SARS, Ebola, and the 1918 influenza outbreak, emphasize the need for robust public health infrastructure, timely communication, and equitable vaccine distribution (World Health Organization [WHO], 2021b). Effective response strategies must prioritize these vulnerable populations by implementing culturally tai-

lored outreach programs and inclusive health policies that ensure all communities are supported during pandemics.

Historically, pandemics have taught valuable lessons that inform current global health strategies. The 1918 Influenza Pandemic demonstrated the importance of non-pharmaceutical interventions, such as social distancing, wearing masks, and quarantining, which are still relevant in managing infectious diseases today (Centers for Disease Control and Prevention [CDC], 2022). The HIV/AIDS pandemic underscored the necessity for sustained global funding and the destigmatization of affected populations, pointing to the need for long-term, multi-sectoral efforts to address both the medical and social aspects of health crises (World Health Organization [WHO], 2021b). The SARS and Ebola outbreaks reinforced the importance of rapid disease detection, containment strategies, and international collaboration to prevent the spread of diseases across borders. These lessons continue to shape modern public health approaches and emphasize the need for preparedness at all levels.

Pandemics not only threaten human health but also disrupt economies on a massive scale. Lockdowns, travel restrictions, and quarantine measures, while essential to controlling disease spread, often have severe economic consequences. Industries such as tourism, transportation, and hospitality are hit hardest, resulting in widespread unemployment and business closures. Low-income countries and vulnerable workers, lacking financial safety nets or access to government support, experience the brunt of these economic disruptions (IOM, 2023). The COVID-19 pandemic has exacerbated existing inequalities, with poorer communities and countries facing more severe health and economic consequences than wealthier ones.

During the COVID-19 pandemic, some ethnic groups faced heightened levels of xenophobia and violence.

In addition to the economic impact, the COVID-19 pandemic also led to an increase in xenophobia, racism, and violence, particularly against ethnic and migrant groups. Certain communities, already marginalized before the pandemic, faced heightened levels of discrimination as misinformation and fear surrounding the virus spread. This social division created a barrier to effective public health measures, as trust in government and healthcare systems eroded in these communities (World Health Organization [WHO], 2021b). As such, addressing the social determinants of health, including racism and xenophobia, is critical in pandemic preparedness and response.

To effectively combat future pandemics and mitigate their impact on global health, it is essential to adopt an approach that integrates robust health infrastructure, global collaboration, and social equity. By learning from past pandemics and addressing systemic vulnerabilities, we can create more inclusive and resilient global health systems that are better prepared for future health crises (IOM, 2023).

7.3. Climate Change as a Global Health Threat

Climate change is increasingly recognized as one of the most significant threats to global health. Rising temperatures, extreme weather events, and environmental degradation have direct and indirect impacts on human health. Climate-related disasters, such as hurricanes, floods, and droughts, exacerbate malnutrition, vectorborne diseases, and mental health conditions (Intergovernmental Panel on Climate Change [IPCC], 2022).

Vulnerable populations, including transcultural communities and migrants, often bear the brunt of these effects. For instance, climate-induced migration forces millions to relocate, often to areas with insufficient health infrastructure. Efforts to mitigate these impacts include strengthening climate-resilient healthcare systems, implementing early warning systems for climate-related health risks, and promoting sustainable development policies (World Health Organization [WHO], 2021a).

The interplay between climate change and global health extends to the increasing burden of non-communicable diseases (NCDs). Rising temperatures and worsening air quality contribute to respiratory and cardiovascular illnesses (World Health Organization [WHO], 2021a). Prolonged exposure to heat can also exacerbate chronic conditions such as diabetes and kidney diseases. Moreover, the stress caused by climate-related displacement and environmental degradation has been linked to a rise in anxiety, depression, and other mental health disorders (Intergovernmental Panel on Climate Change [IPCC], 2022). These challenges necessitate a holistic approach that integrates climate adaptation and mitigation into public health strategies.

Another critical dimension is the impact of climate change on food and water security. Erratic weather patterns and prolonged droughts disrupt agricultural productivity, leading to food shortages and undernutrition, particularly in low-income regions. Additionally, flooding and rising sea levels contaminate freshwater supplies, increasing the prevalence of waterborne diseases like cholera and typhoid. Addressing these issues requires global collaboration to ensure equitable

access to nutritious food and clean water while promoting sustainable agricultural practices (Centers for Disease Control and Prevention [CDC], 2021).

Effective action against climate change and its health implications depends on robust global governance. Governments, international organizations, and non-governmental entities must collaborate to implement policies that prioritize health equity and environmental sustainability (World Health Organization [WHO], 2021a). Investments in renewable energy, green infrastructure, and education campaigns to raise public awareness about climate-health connections are essential. Furthermore, fostering cross-sector partnerships between the health, environmental, and economic sectors will ensure that solutions are both sustainable and inclusive (UNEP, 2022).

Finally, community engagement plays a pivotal role in combating the health effects of climate change. Empowering local communities through education, resources, and participatory decision-making ensures that interventions are culturally appropriate and effective (Centers for Disease Control and Prevention [CDC], 2021). Grassroots efforts, combined with top-down initiatives, create a comprehensive approach to addressing the multifaceted challenges posed by climate change.

By recognizing the interconnectedness of climate change and global health, the international community can take proactive steps toward mitigating these impacts. Strengthening health systems, promoting sustainable development, and fostering resilience will be critical to safeguarding human health in an era of unprecedented environmental change (Intergovernmental Panel on Climate Change [IPCC], 2022).

7.4. Conclusion

iThe interconnectedness of global health, climate change, and pandemics presents complex challenges that require urgent, coordinated action. Vulnerable communities, including migrants, refugees, and international populations, are disproportionately affected by these crises, underscoring the need for inclusive and culturally competent healthcare systems. By embracing policies that address these issues at both the global and local levels, the global health community can work toward building more resilient and equitable health systems, ensuring that all people have access to the care and resources they need to thrive (Intergovernmental Panel on Climate Change [IPCC], (2022).

The intersections of global health, climate change, pandemics, and health of culturally diverse population needs demand an integrated and holistic approach. Strengthening health systems involves investing in infrastructure, improving access to care, and fostering international cooperation.

References

Centers for Disease Control and Prevention (CDC). (2021). *Climate effects on health*. https://www.cdc.gov/climateandhealth/effects/default.htm

Centers for Disease Control and Prevention (CDC). (2022). *Pandemics: Preparedness and response*. https://www.cdc.gov

International Organization for Migration (IOM). (2023). *Migration*. International Organization for Migration. https://www.iom.int/migration

Intergovernmental Panel on Climate Change (IPCC). (2022). *Climate change and health*. https://www.ipcc.ch

United Nations Environment Programme (UNEP). (2022). *Global environment outlook 2022: A roadmap for climate action*. United Nations Environment Programme. https://doi.org/10.18356/9789280734519

UNHCR. (2022). *Refugee data finder*. UNHCR: The UN Refugee Agency. https://www.unhcr.org/refugee-statistics/

World Health Organization (WHO). (2021a). *Climate change and health*. https://www.who.int

World Health Organization (WHO). (2021b). *Global health*. World Health Organization. https://www.who.int/health-topics/global-health

Final Reflection: Linking Global Health Crises to the EMPOWER Model

by Małgorzata Szkup

This chapter illustrates how **climate change** and the **COVID-19 pandemic** have exposed and deepened existing health inequalities, disproportionately affecting **transcultural communities, migrants**, and **refugees**. As such, its content directly supports the core values of the EMPOWER model, particularly in the areas of Effectiveness, Multiculturalism, Wellness, and Education Resources.

By highlighting the need for **resilient health systems, equitable health policies**, and **culturally sensitive responses**, the chapter emphasizes the importance of cultural competence in addressing global threats. Addressing patients' psychological, linguistic, and social needs in times of crisis exemplifies **person-centered care**, a key EMPOWER principle.

The chapter also reinforces EMPOWER's call for **international collaboration and health education**, stressing that systemic, inclusive strategies are essential in the face of pandemics and climaterelated health risks.

In short, the chapter shows that **resilience and equity in healthcare** are achievable only through the integration of cultural diversity—an idea at the heart of the EMPOWER model.

Chapter 8

Aging of the population

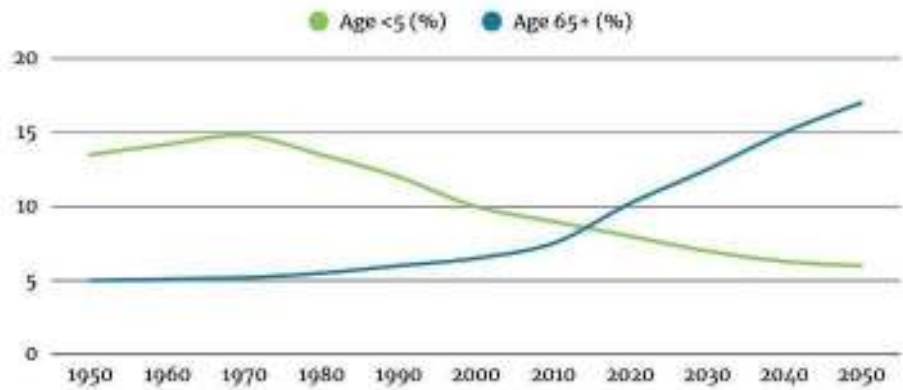
ELENA ROUSOU, PANAGIOTA ELLINA, PARASKEVI CHARITOU
Cyprus University of Technology (Cyprus)

Healthcare professionals must understand the global context of healthcare to provide person-centered, culturally competent, and ethically sound care (Malhotra, 2023; Leininger & McFarland, 2002).

By 2050, the global population aged 65 and older is expected to double to 1.5 billion, representing 16% of the total population. While advancements in healthcare and living conditions have increased healthy life expectancy and fueled the growth of the "silver economy," challenges such as rising frailty, chronic diseases, and health disparities among older adults persist, raising important health equity concerns (Padeiro et al., 2023)

8.1. Introduction

Population aging is a global trend driven by lower fertility rates and increased life expectancy. Life expectancy has risen by 25 years since 1950, with individuals reaching 65 now expected to live an additional 16.8 years. By 2030, the number of older persons will surpass youth and double the number of children under five, with the most rapid growth occurring in developing countries. This demographic shift is significantly impacting caregiving needs, with increased demand for both formal and informal care. The growing need for healthcare, care, and social support services calls for expanded education in geriatrics and gerontology for healthcare and social care professionals (United Nations International Day of Older Persons [UNIDOP], 2024).



Graph 1. Young Children and Older People as a Percentage of Global Population: 1950-2050 (United Nationas. World Population Prospects: The 210 Revision).

Aims

Through this chapter students will enhance their attitudes, knowledge and skills in:

- Enhancing understanding of global aging trends and their implications for healthcare.
- Promoting cultural competence in addressing the unique needs of culturally diverse aging populations.
- Equiping students with strategies to improve health outcomes and equity for diverse older adult communities.

Learning Outcomes

By the end of this chapter, readers will be able to:

- Explain global trends in aging and their impact on healthcare systems.
- Identify common challenges faced by transcultural aging communities.
- Apply principles of cultural competence in clinical scenarios involving older adults.

- Recognize relevant legislation and treaties supporting equitable care for aging populations.
- Reflect on strategies to balance professional responsibilities and personal wellbeing in providing transcultural care.

Relevant Definitions and Terms

Aging: progressive physiological changes in an organism that lead to senescence, or a decline of biological functions and of the organism's ability to adapt to metabolic stress. Aging begins as soon as adulthood is reached and is as much a part of human life as infancy, childhood, and adolescence. Physiological decline occurs across all body systems, diminishing the body's ability to maintain homeostasis when faced with stressors. This decline often makes it difficult to differentiate between pathological conditions and the normal aging process. Multisystem functional deterioration reduces the capacity to cope with stressors, leading to decompensation and frailty, which may present as confusion or reduced mobility. Symptoms like breathlessness or falls often have multiple underlying contributing factors (Preston & Biddell., 2021).

Ageism: The Global Report on Ageism, developed by WHO in collaboration with the Office of the High Commissioner for Human Rights, the United Nations Department of Economic and Social Affairs and the United Nations Population Fund, defines ageism as 'Unfair treatment of people who are becoming old or who are old, the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) towards others or ourselves based on age. It can be institutional, interpersonal, or self-directed. It begins in childhood and is socially constructed, affecting people of all ages. Ageism has severe consequences, including reduced social well-being, lower quality of life, poor mental and physical health, and increased risk of early death' (WHO, 2021).

Cultural aging: refers to the process of aging that occurs within the context of multiple or intersecting cultural backgrounds. It emphasizes how various cultural factors influence perceptions, experiences, and expectations of aging. This concept recognizes that aging is not a uniform experience and can be shaped significantly by cultural norms, values, and practices (Fernandes, 2023).

"Ageism in healthcare significantly affects the quality of care that older adults receive. Stereotypes such as assuming all older patients are frail or technologically inept can lead to inadequate or dismissive treatment. Systemic barriers, including lack of age-friendly facilities and limited training in geriatric care, exacerbate these issues"(Ayalon, Tesch-Römer, et al., 2018).

Transcultural care: Providing transcultural care is a professional responsibility and moral obligation for healthcare workers, emphasized by global healthcare organizations. Culturally sensitive care enhances patients' well-being, satisfaction, and health outcomes. However, delivering such care is complex, requiring nurses to understand diverse cultures, reflect on their own cultural biases, and apply respectful, culturally appropriate interventions. This complexity is further influenced by interpersonal, organizational, and systemic factors, making it challenging for healthcare workers and students to navigate within healthcare systems while providing effective transcultural care (Shahzad, et al., 2021).

Principles and Values

Understanding global health and aging is vital for medical and health sciences students' due to the growing diversity in patient populations and the increasing number of aging individuals worldwide. The integration of transcultural care principles ensures equity, respect for cultural diversity, and improved patient outcomes. The principles and values of ageing and culturally competent healthcare emphasize respect, inclusivity, and responsiveness to the diverse needs of older adults. These principles aim to ensure that healthcare services are accessible, equitable, and effective in addressing the unique challenges faced by ageing populations, particularly those from diverse cultural backgrounds (Hanefeld, et al., 2021; WHO,2015).

Key principles and values:

- Dignity and Respect: Every individual, regardless of age, deserves to be treated with dignity, respect, and fairness. This includes respecting the autonomy and rights of older adults to make decisions about their own care and lives.
- Independence and Autonomy: Supporting older adults in maintaining their independence, decision-making capabilities, and ability to live in a manner that aligns with their preferences and values.
- Social Participation: Older adults should have opportunities to participate fully in society, including in family, community, and work life, to combat isolation and promote inclusion.
- Equity and Access: Striving to eliminate healthcare disparities and ensuring that all cultural groups, including older adults from marginalized or minority backgrounds, have equal access to quality care.
- Respect for Cultural Differences: Recognizing that cultural backgrounds influence how people perceive and experience health and illness and respecting those differences in care delivery (WHO,2015).

8.2. Aging of the Population as a Global Challenge

8.2.1. Demographic Shift

The phenomenon of population aging, often referred to as the "Silver Tsunami," marks a significant shift in demographic history. Traditionally, societies were youthful, with children making up a large portion of the population and the elderly constituting a small minority. This pattern was consistent across various civilizations and religious or ideological systems. However, by 2020, a demographic shift occurred where the elderly population began to outnumber the young. This global trend towards aging began in industrialized nations and now characterizes the majority of the world (Jakovljevic, et al., 2020). A realistic projection of a future with 95 million older adults must strike a balance, considering both the challenges of caregiving and the valuable contributions this population can offer (Greenlee, 2020; Longev,2021).

8.2.2. Ageing and Health

The COVID-19 pandemic has highlighted the vulnerability of geriatric care, revealing a troubling truth: global healthcare systems are inadequately prepared to meet the needs of an ageing population (Longev,2021).

WHO released the Baseline report for the Decade of Healthy Ageing, which provides a snapshot of where we are in 2020 and where we aim to be by 2030. The report brings together data available for measuring healthy ageing, presents the experience of countries that have been successful in starting healthy ageing initiatives, and discusses what is needed to promote collaboration and better measure progress towards healthy ageing. In the following video watch an introduction to the WHO Baseline report:

https://youtu.be/ShmemfpkVLQ?si=GI4n1jzB8RopeHYx

Promoting healthy aging involves a holistic approach encompassing physical, mental, and social well-being. Early interventions and lifestyle choices play a significant role in mitigating the impact of age-related diseases and enhancing the quality of life in older age (CDC,2024). The most common age-related diseases include neurodegenerative disorders, cancer, cardiovascular conditions, and metabolic disorders.

8.2.3. Dementia and Alzheimer Disease

Aging is the primary risk factor for developing neurodegenerative diseases like Alzheimer Disease and Related Dementias (ADRD). Alzheimer's disease (AD), the most prevalent neurodegenerative disorder globally, sees its incidence rise with advancing age, posing challenges to healthcare systems and economies (Li, et al., 2021). In 2010, dementia contributed to ten million disability-adjusted life years (DALYs) among older adults, with 44% of the burden in low- and middle-income regions. Dementia involves progressively disabling cognitive impairments and its behavioral and psychological symptoms significantly impact quality of life, causing caregiver strain/burden and often leading to institutionalization. The incidence of dementia doubles approximately every 5.9 years, increasing from 3 per 1000 person-years at ages 60-64

to 175 per 1000 person-years at age 95 and older. Early diagnosis is crucial, allowing patients to engage in advanced care planning while they still have decision-making capacity (Jakovljevic, et al., 2020). Despite improved access to health services, gaps in equity and efficiency of dementia care and management remain.

Promoting Dementia Awareness

Promoting dementia awareness is crucial for improving outcomes, reducing stigma, and fostering inclusive, supportive environments for individuals living with dementia. Dementia awareness involves understanding the condition and recognizing the signs, symptoms, and risk factors (Alzheimer's Association, 2021). Early diagnosis can significantly improve the management and quality of life for individuals with dementia (World Health Organization, 2020). Furthermore, promoting dementia-friendly environments and reducing stigma are essential components of dementia awareness, as they ensure inclusivity and support for those affected by dementia (Alzheimer's Disease International, 2021).

Benefits of Dementia Awareness:

- Increased early detection and treatment leading to better management of symptoms.
- Better support for caregivers and families, reducing stress, burden and improving quality of life.
- More dementia-friendly communities that foster inclusion, understanding, and participation.
- Empowerment of individuals with dementia to remain active and engaged in society.

Dementia prevention

As people live longer, the number of people who live with dementia continues to rise, this underscores the urgency of identifying and implementing prevention strategies. Educating the public about modifiable risk factors, such as education, hearing loss, hypertension, smoking, obesity, depression, physical inactivity, diabetes, alcohol consumption, traumatic brain injury, air pollution, social isolation, untreated vision loss, high LDL cholesterol, can also help in prevention efforts and significantly reduce the risk of dementia. (Livingston, et al., 2020). The Lancet report suggests that modifying these 14 risk factors could prevent or delay nearly half of dementia cases. This calls for ambitious prevention efforts, including both population-level policy changes and individualized interventions. Prevention should prioritize equity and focus on high-risk groups, with interventions beginning early and continuing throughout life. The report stresses that risk is modifiable regardless of genetic predisposition (APOE genetic status) and that multicomponent interventions can benefit individuals at both high and low genetic risk (Livingston, et al., 2024).

Specific Recommendations include:

- Education: Ensure access to good quality education and encourage cognitive stimulation in midlife.

- Hearing loss: Make hearing aids accessible and reduce harmful noise exposure.
- Depression: Treat depression effectively.
- Head Protection: Encourage helmets for contact sports and cycling.
- Physical activity: Promote exercise to reduce dementia risk.
- Smoking: Educate and regulate smoking, offering cessation support.
- Hypertension: Maintain systolic blood pressure of 130 mm Hg or less from the age of 40 years
- Cholesterol: Detect and treat high LDL cholesterol from midlife.
- Weight management: Prevent and treat obesity early to reduce diabetes risk.
- Diabetes: Prevent and control Diabetes
- Alcohol consumption: Reduce excessive drinking through price control and awareness.
- Social participation: Reduce social isolation through age-friendly environments and community engagement.
- Vision loss: Provide accessible screening and treatment for vision loss.
- Air pollution: Reduce exposure to harmful pollutants (Livingston, et al., 2024).

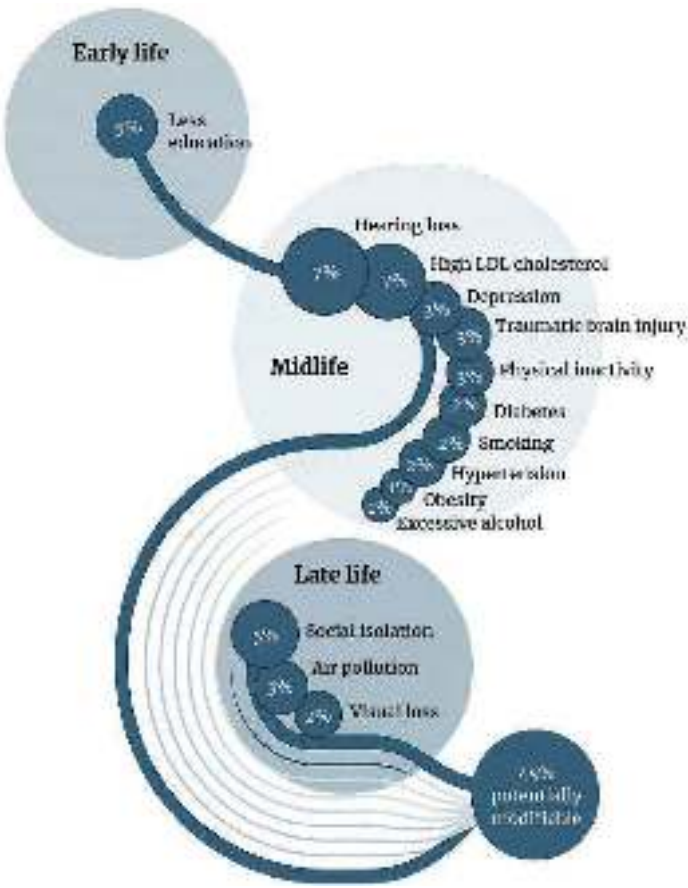


Fig.11. Life-course model of the contribution of modifiable risk factors to dementia (Livingston, et al., 2024)

Cultural Competence in Dementia Care

Cultural competence in dementia care is essential for providing effective and respectful support to individuals from diverse backgrounds. It involves understanding and integrating patients' cultural beliefs, values, and practices into their care plans. This approach enhances patient engagement, satisfaction, and overall care outcomes.

Key Aspects of Cultural Competence in Dementia Care:

- Understanding Cultural Perspectives: Recognizing that cultural beliefs significantly influence how dementia is perceived, diagnosed, and managed. For instance, in some cultures, dementia may be viewed as a natural part of aging, leading to delays in seeking medical intervention (Lark, et al., 2018)
- Communication: Addressing language barriers and understanding culturally influenced communication styles are crucial. Effective use of interpreters and culturally appropriate materials can improve patient-provider relationships (Alzheimer's Society).
- Family Roles: In many cultures, family members are the primary caregivers for older adults with dementia. Recognizing and respecting these family dynamics is vital for developing effective care plans (Shishira, 2024).
- Tailoring Interventions: Developing care plans that respect cultural dietary preferences, caregiving traditions, and health beliefs while promoting evidencebased practices.
- Building Trust: Establishing trust through culturally sensitive interactions, including the use of nonverbal communication and engagement with community resources, enhances patient comfort and cooperation. (Dementia UK, 2021).

8.3. Health Care Professionals Attitudes Towards Older Patients

Research indicates that healthcare professionals' attitudes toward older people significantly influence the quality of care and communication they provide. Studies highlight several key findings:

Negative Attitudes Impact Communication: Nurses with negative attitudes toward aging tend to have shorter, more superficial, and task-oriented conversations with older patients. These interactions often involve a patronizing tone and exclude patients from consultations or decision-making (Caris-Verhallen, et al., 1999).

Low Expectations and Detached Care: Nurses with unfavorable attitudes toward older patients exhibit lower expectations for their rehabilitation and more detached treatment. They are also less likely to use humor or remember older patients' names, compared to younger patients (McLafferty & Morrison, 2004).

Exclusion from Medical Conversations: Across disciplines (physicians, nurses, and social workers), older patients are often excluded from discussions about their own care. Instead, healthcare providers may bypass them to communicate with younger family members or make clinical decisions without meaningful input from the patient. Reasons for this include a lack of self-awareness, the perception

that discussing care with younger family members is easier and failing to regard the older patient as an individual (Ben-Harush, et al., 2016).

Overall, these patterns reveal how ageism in healthcare can undermine patient-centered care and compromise the dignity of older patients.

8.4. How Culture Influences Perception of Aging

In today's world, the combination of urbanization, rising living costs, and cultural shifts driven by global interconnectedness is contributing to a transition from traditional joint family systems, where the elderly are cared for at home, to more institutional-based care systems. In many Eastern cultures, it is expected that younger generations will care for their elderly family members, viewing it as a familial duty. As a result, older adults often receive care at home, frequently living with their children or other younger relatives. In contrast, in countries like the U.S., it is common for older adults to reside in "retirement communities," where many choose to live independently within a community setting (Fernandes, 2023).

Perceptions of aging vary across cultures, influencing how older adults are viewed and treated. In some cultures, older adults are respected for their wisdom, while in others, aging may be seen negatively. This can affect their self-esteem and well-being. Western societies often value youth and beauty, leading to a negative view of aging. In contrast, many Eastern and African cultures value older adults for their experience and knowledge, with strong family and community support systems in place. Healthcare workers' understanding of these cultural differences is crucial for providing personalized care, improving communication, supporting family involvement in decision-making, and encouraging community engage-

ment. Cultural awareness training enhances healthcare workers' ability to serve older adults from diverse backgrounds (Mansor & Hui, 2020).

8.5. Challenges Faced by Older Immigrants Aging in Their Host Countries

Economic difficulties: Older immigrants often face economic difficulties, being overrepresented among vulnerable and disadvantaged groups. They tend to work in lowpaying jobs with poor job security and minimal pension benefits, leading to a reliance on state pensions in retirement. Even those with occupational pensions typically receive low amounts due to periods of unemployment or early retirement. Non-European older immigrants in Europe are particularly disadvantaged, as they generally cannot transfer pension rights, unlike their European counterparts (Ayalon, Tesch-Römer et al., 2018).

Limited Access to Services: Older immigrants often face limited access to government services due to language barriers, lack of education, insufficient cultural capital, and inadequate information. They also struggle with navigating bureaucracy and often rely on family or community support. Professionals typically attribute this underutilization of services to the immigrants themselves, rather than systemic issues. However, the lack of inclusive policies, insufficient attention from mainstream institutions, and inadequate multicultural training for service providers contribute significantly to these accessibility challenges (Ayalon, Tesch-Römer, et al., 2018).

Social Isolation (Loneliness): Social isolation is a significant and ongoing global issue affecting many older adults, particularly immigrant and refugee seniors. It is often linked to factors such as racism, discrimination, language barriers, weak social networks, and separation from friends and family. Identifying socially isolated older adults remains a major challenge. A more comprehensive understanding of social isolation is crucial for informing policy, program development, and research aimed at supporting diverse older adults (Johnson, et al., 2021).

8.6. What do European Treaties and Conventions Say on the Topic?

While specific laws vary by country, common themes include anti-discrimination, social protection, healthcare access, and support for independent living. EU treaties and legislation provide robust protections against age discrimination, focusing on protecting the rights of older adults, promoting their well-being, and ensuring their participation in society.

Article 19 of the Treaty on the Functioning of the EU empowers the EU to legislate against age discrimination (European Union, 2007). **Article 21 of the Charter of Fundamental Rights** explicitly prohibits age discrimination, while **Article 25** recognizes the elderly's right to dignity, independence, and social participation (European Union, 2000). **The European Convention on Human Rights**, though not

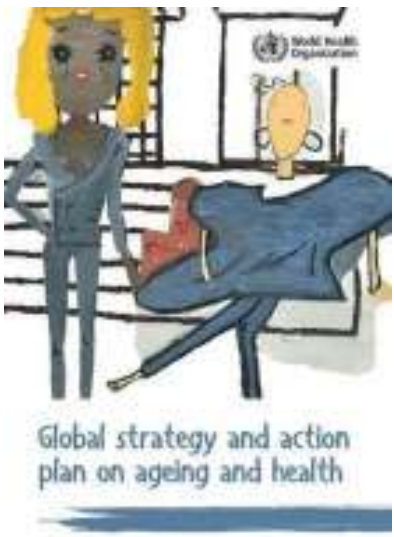
explicitly addressing age discrimination, has had its anti-discrimination clause interpreted to include age (Council of Europe, 1950). **The European Court of Justice's (ECJ)** further establishes age non-discrimination as a general principle of EU law, ensuring compliance across EU legislation - Mangold case (Mangold v. Helm, 2005). Mangold v Helm (2005) C-144/04 was a landmark case before the European Court of Justice (ECJ) concerning age discrimination in employment. The case involved Mr. Mangold, a 56-year-old worker in Germany, who was employed on a fixed-term contract under German law, which permitted such contracts for older workers without justification. He challenged the law, arguing that it discriminated against him based on age. The ECJ held in its judgment the German law contravened the Employment Equality Framework Directive, even though it did not have to be implemented until the end of 2006. It said that, in general terms, legislation that lets employers treat people differently because of their age "offends the principle" in international law of eliminating discrimination on the basis of age. The ECJ ruled that national courts must set aside any provision of national law which conflicts with the directive. Even before the full implementation of Directive 2000/78/EC (which prohibits age discrimination in employment), national courts must disaply laws that are incompatible with EU fundamental principles.

European Social Charter of the Council of Europe: The European Social Charter is a human rights treaty established by the Council of Europe. For over 60 years, it has safeguarded the social and economic rights of citizens across Europe. Initially opened for signature on 18 October 1961 in Turin, Italy, the Charter has evolved over time to address the challenges of modern societies by incorporating new rights. Despite these revisions, the Charter remains central to the Council of Europe's core objectives—human rights, the rule of law, and democracy—underscoring that these ideals cannot be fully realized without the protection of social rights. Article 23 is the first human rights treaty provision to specifically protect the rights of the elderly. It encourages member states to ensure adequate income, healthcare, and participation in social and cultural life for older adults. It enables elderly persons to remain full members of society and requires States Parties to establish an adequate legal framework making it possible to combat age-based discrimination and providing for a procedure for "assisted decision-making" (Council of Europe, 1961).

Watch the related video "Protecting the rights of older persons":
https://youtu.be/GB7Vr8tlOuE?si=aXOimGVI6xk8EAlC.

Employment Equality Framework Directive (2000/78/EC) prohibits age discrimination in employment and vocational training across the European Union. It aims to ensure equal treatment and opportunities for individuals regardless of their age in the workplace (European Commission. Legislation: Employment Equality Directive (2000/78/EC).

WHO, Global Strategy and Action Plan on Ageing and Health (2016-2020): At the World Health Assembly in 2016, 194 countries adopted a Global strategy and action plan on ageing and health (2016–2030). The Strategy provided the vision and objectives for 14 years (2016–2030), and an Action Plan outlining actions that need to be taken between 2016–2020 to develop the evidence base and partnerships for a Decade of Healthy Ageing (2021–2030).



The aim of the strategy was to enhance the quality of life for older individuals by promoting healthy aging and addressing the challenges posed by population aging. The plan focused on ensuring that older adults can lead independent lives and have access to the services and support they need, while also fostering a society that values their contributions.

The Strategy (2016–2020) had two goals:

- five years of evidence-based action to maximize functional ability that reaches every person
- by 2020, establish evidence and partnerships necessary to support a Decade of Healthy Ageing from 2020 to 2030.

WHO's contributions to the Global Strategy on Ageing and Health (2016–2020) significantly advanced its two main goals. For Goal 1, WHO played a crucial role in strengthening the scientific evidence on healthy ageing, producing guidelines, and advocating for ageing-related policies. The World Report on Ageing and Health (WRAH) and other research efforts informed national strategies, leading to a growing number of countries developing policies aligned with the strategy. While this progress cannot be solely attributed to WHO, it reflects increasing global awareness of ageing and health issues. For Goal 2, WHO successfully mobilized Member States, UN agencies, civil society, and researchers to lay the groundwork for the Decade of Healthy Ageing (2021–2030). The draft proposal for the Decade outlined four key areas of action, including tackling ageism, creating age-friendly environments, improving integrated care, and expanding long-term care. WHO also launched initiatives such as Healthy Ageing for Impact in the 21st Century, an online training program for policymakers. However, challenges remain, including the need for stronger leadership, clearer roles for partners, and more equitable country participation in the Decade's implementation (WHO: Evaluation Report, 2020).

The UN Decade of Healthy Ageing (2021–2030): a global initiative led by the World Health Organization (WHO) as a continuation to Global Strategy on Ageing and Health (2016–2020) aiming to promote the well-being, rights, and dignity of older people. It aligns with the United Nations' Sustainable Development Goals (SDGs) and focuses on improving the quality of life for older populations worldwide. The initiative recognizes the growing global aging population and aims to foster healthy aging in an inclusive and sustainable manner. The UN Decade of Healthy Ageing seeks to address the challenges and opportunities of an aging world by fostering environments and systems that promote health, autonomy, and engagement for older people. It emphasizes the importance of collaboration across sectors and the need for innovative approaches to create age-friendly societies. Key objectives include:

A) Combat Ageism:

Address stereotypes and discrimination against older people while promoting positive views on aging and their contributions.

Actions to Combat Ageism:

- Raise awareness through public education campaigns about the value and potential of older adults.
- Develop policies and laws to protect against age-based discrimination in employment, healthcare, and other areas.
- Promote intergenerational programs to encourage mutual understanding and break down stereotypes between younger and older generations.

B) Create Age-Friendly Environments:

Develop accessible public spaces and foster communities that support active and healthy aging.

Age-Friendly Communities:

- Ensure accessible public spaces, transportation, and housing that meet the needs of older individuals.
- Promote community engagement opportunities, including volunteering and participation in social, cultural, and recreational activities.
- Improve accessibility to services such as healthcare, shopping, and entertainment through physical and digital infrastructure.

C) Ensure Integrated Care:

Provide person-centered, comprehensive healthcare services tailored to the needs of older individuals.

Integrated Care Models:

- Emphasize coordination among primary care providers, specialists, and community-based services to address the complex health needs of older adults.
- Focus on preventive care, early diagnosis, and management of chronic conditions to improve health outcomes and quality of life.
- Use technology such as telemedicine to increase access to care, especially for those in remote or underserved areas.

> *"By acting together, we can add quality to quantity and give all people the chance to lead a meaningful life, no matter their age. Together, we can make every year count – not by the numbers, but by how we live and grow in between"*
>
> *- UN Decade of Healthy Ageing, 2022*

D) Support Long-Term Care:

Enhance long-term care systems to respect the rights, dignity, and preferences of older adults with declining capacity.

Enhancing Long-Term Care Services:

- Develop community-based care options that allow older adults to age in place rather than institutionalizing them.
- Provide adequate training and support for caregivers, including family members and professional staff.
- Ensure long-term care policies address issues of abuse, neglect, and exploitation.
- Overall, the initiative is a call to action for governments, civil society, and stakeholders to improve the lives of older people, enabling them to live longer, healthier, and more fulfilling lives (Decade of Healthy Ageing, 2022).

Watch the following video about Decade of Healthy Ageing:
https://youtu.be/2Ka3a3X5RRw?si=aTfBT505f1BLw7fB

References

Alzheimer's Association. (2021). *Alzheimer's disease facts and figures*. Alzheimer's Association. https://www.alz.org/facts

Alzheimer's Disease International. (2021). *World Alzheimer Report 2021: Journey through the diagnosis of dementia*. Alzheimer's Disease International. https://www.alz.co.uk/research/world-report

Alzheimer's Society. (n.d.). *Cultural sensitivity and awareness*. https://www.alzheimers.org.uk/dementia-professionals/dementia-experience-toolkit/howrecruit-people-dementia/cultural-sensitivity-and-awareness

Ben-Harush, A., Shiovitz-Ezra, S., & Doron, I. (2016). Ageism in the health care system: Providers, patients, and systems. *The Gerontologist*, 57(4), 707-718. https://doi.org/10.1093/geront/gnw076

Caris-Verhallen, W. M., Kerkstra, A., & Bensing, J. M. (1999). The role of communication in nursing care for older people: A review of the literature. *Journal of Advanced Nursing*, 29(4), 915-933. https://doi.org/10.1046/j.1365-2648.1999.00966.x

CDC. (2024). *Healthy aging at any age*. https://www.cdc.gov/healthy-aging/about/index.html

Council of Europe. (1950). *European Convention on Human Rights*. https://www.echr.coe.int

Council of Europe. (1961). *European Social Charter*. https://www.coe.int/en/web/european-socialcharter

Court of Justice of the European Union. (2005). *Mangold v. Helm, Case* C-144/04. https://curia.europa.eu

Dementia UK. (2021). *Cultural and religious awareness within dementia care*. https://www.dementiauk.org/news/cultural-and-religious-awareness-within-dementia-care/

European Commission. (n.d.). *Legislation: Employment Equality Directive (2000/78/EC)*. Employment, Social Affairs & Inclusion. https://employment-social-affairs.ec.europa.eu/policies-andactivities/rights-work/tackling-discrimination-work/legislation-employment-equality-directive-200078ec_en

European Union. (2000). *Charter of Fundamental Rights of the European Union*. Official Journal of the European Communities, C 364/1. https://www.europarl.europa.eu

European Union. (2007). *Treaty on the Functioning of the European Union (TFEU)*. Official Journal of the European Union, C 326/47. https://www.europa.eu

Fernandes, D. (2023). *Aging across borders: How we age around the world*. Psychology Today. https://www.psychologytoday.com/us/blog/non-weird-science/202310/aging-across-bordershow-we-age-around-the-world

Greenlee, K. (2020). *Overcoming the Silver Tsunami*. American Society on Ageing. https://generations.asaging.org/silver-tsunami-older-adults-demographics-aging

Hanefeld, J., & Fischer, H. T. (2021). Global health: Definition, principles, and drivers. In I. Kickbusch, G. L. Tang, & R. Horton (Eds.), *Handbook of global health* (pp. 3–27). Springer. https://doi.org/10.1007/978-3-030-05325-3_4-1

Johnson, S., Bacsu, J., McIntosh, T., Jeffery, B., & Novik, N. (2021). Competing challenges for immigrant seniors: Social isolation and the pandemic. *Healthcare Management Forum*, 34(5), 266-271.

Lark, J. L., Phoenix, S., Bilbrey, A. C., et al. (2018). Cultural competency in dementia care: An African American case study. *Clinical Gerontologist*, 41(3), 255-260. https://doi.org/10.1080/07317115.2017.1420725

Leininger, M. M., & McFarland, M. R. (2002). Transcultural nursing: Concepts, theories, research and practice. *Open Journal of Nursing*, 3(1).

Li, Z., Zhang, Z., Ren, Y., et al. (2021). Aging and age-related diseases: From mechanisms to therapeutic strategies. *Biogerontology*, 22(2), 165-187. https://doi.org/10.1007/s10522-021-09910-5

Livingston, G., Sommerlad, A., Orgeta, V., et al. (2020). Dementia prevention, intervention, and care. *The Lancet*, 396(10248), 413-446. https://doi.org/10.1016/S0140-6736(20)30367-6

Livingston, G., Huntley, J., Liu, K. Y., et al. (2024). Dementia prevention, intervention, and care: 2024 report of the Lancet standing commission. *The Lancet*, 404(10452), 572-628. https://doi.org/10.1016/S0140-6736(24)01296-0

Longev, L. H. (2021). Care for ageing populations globally. *Lancet Healthy Longevity*, 2(4), e180.

Malhotra, S. (2023). *Global Health and Healthcare Strategic Outlook: Shaping the Future of Health and Healthcare*. World Economic Forum.

Mansor, S., & Hui, M. K. (2020). Cultural attitudes towards older adults: A comparative study. *Journal of Aging & Social Policy*, 32(4), 413-430. https://doi.org/10.1080/08959420.2020.1802422

McLafferty, E., & Morrison, F. (2004). Attitudes towards hospitalized older adults. *Journal of Advanced Nursing*, 47(4), 446-453. https://doi.org/10.1111/j.1365-2648.2004.03124.x

Padeiro, M., Santana, P., & Grant, M. (2023). Global aging and health determinants in a changing world. In J. Doe & A. Smith (Eds.), *Aging* (pp. 3–30). Academic Press.

Preston, J., & Biddell, B. (2021). The physiology of ageing and how these changes affect older people. *Medicine*, 49(1), 1-5. https://doi.org/10.1016/j.mpmed.2020.10.011

Shahzad, S., Ali, N., Younas, A., & Tayaben, J. L. (2021). Challenges and approaches to transcultural care: An integrative review of nurses' and nursing students' experiences. *Journal of Professional Nursing*, 37(6), 1119-1131. https://doi.org/10.1016/j.profnurs.2021.10.001

Shishira, S. (2024). How race and culture can affect Alzheimer's care. Retrieved January 26, 2025, from https://www.webmd.com/alzheimers/race-culture-alzheimers-care

World Health Organization. (2015). *World Report on Ageing and Health*. https://www.who.int/publications/i/item/9789241565042/

World Health Organization. (2020). *Risk reduction of cognitive decline and dementia: WHO guidelines*. World Health Organization. https://www.who.int/publications/i/item/9789241550579

World Health Organization. (2021). *Global report on ageism*. https://www.who.int/teams/socialdeterminants-of-health/demographic-change-and-healthy-ageing/combatting-ageism/globalreport-on-ageism

Final Reflection: Population Aging and the EMPOWER Model

by Małgorzata Szkup

This chapter emphasizes that **global population aging** presents significant challenges for healthcare systems in terms of equity, empathy, and cultural adaptation—challenges that align closely with the core pillars of the EMPOWER model, particularly Multiculturalism, Professionalism, Wellness, and Education Resources.

The authors highlight the need for **culturally competent geriatric care**, the fight against ageism, and the development of **age-friendly environments**—all of which support the EMPOWER values of **WELLNESS** and **EFFECTIVENESS**. The emphasis on **individualized care for older adults** and on recognizing their cultural identities and values mirrors EMPOWER's call for **respectful, reflective, and culturally aware healthcare**.

The chapter also stresses the importance of dementia prevention and aging-related education, reinforcing the **Education Resources** component of the model and promoting the continuous development of healthcare professionals.

In short, this chapter strengthens EMPOWER's core message: **care for aging populations must be culturally informed, ethically grounded, and focused on dignity and well-being—regardless of age or background**.

Multi Culti Med

Chapter 9

Effective Multicultural Communication and Collaborative Practices:

Strategies for Inclusivity and Dialogue

KARMEN ERJAVEC, SABINA KRSNIK
University of Novo Mesto (Slovenia)

Effective multicultural communication and collaboration thrive on the foundation of empathy, active listening, and mutual respect, transforming diversity into a powerful tool for inclusivity and meaningful dialogue.

9.1. Introduction

Effective multicultural communication is vital for healthcare professionals working in increasingly diverse environments. **Respect** for diversity is a cornerstone principle, as patients and colleagues bring unique cultural backgrounds, beliefs, and values to the healthcare setting. Embracing this diversity not only fosters trust but also improves patient outcomes and team dynamics. **Empathy and understanding** are equally essential; healthcare professionals must actively seek to understand patients′ and colleagues' perspectives, particularly regarding cultural norms related to health, illness, and treatment. This requires **cultural humility**—a continuous willingness to learn about and adapt to cultural differences without judgment. **Clear and transparent communication** is crucial, ensuring that medical information is conveyed in a way that respects the patient's cultural context and avoids ambiguity. **Active listening** further supports these efforts, enabling professionals to address concerns effectively while building rapport. **Conflict sensitivity**, another key principle, empowers healthcare teams to manage differences constructively, focusing on shared goals such as patient well-being rather than cultural misunderstandings (Samovar, et al., 2017).

In addition to these principles, healthcare professionals should embrace values that promote **inclusivity and collaboration** in their practice. **Mutual respect** is fundamental, as it acknowledges the inherent **dignity** of everyone, regardless of their cultural or linguistic background. Inclusivity ensures that patients and colleagues feel valued and empowered to express their perspectives, which is critical for shared decision-making. **Integrity and honesty** in communication build trust, especially when addressing sensitive topics related to health and care. **Collaboration** enhances team effectiveness by leveraging diverse perspectives to develop innovative solutions. Equally important is **empowerment**—encouraging marginalized groups, such as non-native speakers or underserved communities, to actively participate in their care or professional environment. By adopting these principles and values, healthcare professionals create a more equitable and effective system of care that not only respects cultural differences but uses them as a strength to enhance patient care and professional growth in a multicultural healthcare context (Samovar, et al., 2017).

Aims

Through this chapter students will enhance their attitudes, knowledge and skills in:

- **Developing effective communication skills**, including active listening and empathy. Through practical exercises and case studies, students will enhance their ability to listen actively and empathetically. These skills are essential for understanding patients' needs, building strong therapeutic relationships, and fostering a collaborative environment within healthcare teams.
- **Defining key concepts related to multicultural communication**, such as cultural competence, linguistic diversity, implicit biases, and stereotypes. Understanding these concepts will help students navigate cross-cultural interactions with confidence and respect.

- **Recognizing and overcoming barriers to multicultural communication**, including language differences, cultural misunderstandings, and unconscious biases. Students will explore strategies to ensure respectful and effective interactions with patients and colleagues from diverse backgrounds.
- **Enhancing conflict resolution skills in multicultural contexts** by learning techniques to manage and resolve conflicts arising from cultural differences. Through a focus on shared goals, such as patient well-being, students will develop strategies to turn conflicts into opportunities for growth and collaboration.

Learning Outcomes

By the end of this chapter, students will be able to:

- to **communicate effectively**, including understanding the importance of active listening and empathy, and clarity in their interactions with patients and colleagues.
- understand the importance of **culturally appropriate verbal and non-verbal communication techniques**, which are essential for building trust and understanding in diverse settings
- **recognize and overcome barriers to multicultural communication**. Students will identify common challenges such as language differences, cultural misunderstandings, implicit biases, and stereotypes. They will learn strategies to address these barriers, ensuring respectful and effective interactions with patients and colleagues from diverse backgrounds.
- encouraged to **leverage the strengths of cultural diversity** to foster innovation and problem-solving within healthcare teams.
- **resolve conflicts in multicultural contexts**. Students will learn techniques to manage and resolve conflicts arising from cultural misunderstandings. By focusing on shared goals such as patient well-being, they will develop strategies to turn conflicts into opportunities for growth and collaboration.

Relevant Definitions and Terms

Understanding key definitions and terms provides a basic framework for medical and health science students to navigate the healthcare system, where diversity among patients and professionals is increasingly commonplace.

Multicultural communication refers to exchanging information and ideas among individuals from diverse cultural backgrounds in ways that respect and bridge cultural differences. According to Gudykunst (2003), it emphasizes understanding the nuances of verbal and non-verbal communication across cultures to achieve mutual understanding. In healthcare, multicultural communication is about language proficiency and recognizing cultural values, beliefs, and practices that influence patient behaviour and treatment outcomes.

Effective cultural communication refers to the ability of individuals or groups to effectively exchange information and understand meanings within the context of cultural diversity. This includes verbal, non-verbal, and symbolic communication (Gudykunst, 2005). Effective communication can be achieved through strategies such as **active listening**, avoiding assumptions and stereotypes, and using inclusive language and behaviour. Active listening involves paying close attention to speakers with the intent to understand and empathize, considering cultural contexts (Brownell, 2012). **Avoiding assumptions and stereotypes** requires refraining from generalizations or prejudiced judgments based on cultural differences, focusing instead on individual experiences (Hofstede, et al., 2010). **Inclusive language and behavior** ensure all individuals feel respected, regardless of their cultural backgrounds (Neuliep, 2020).

Linguistic competence refers to the ability of healthcare systems and providers to communicate effectively with patients in their preferred language, including the provision of interpretation and translation services. This term emphasizes the elimination of language barriers in care delivery (Office of Minority Health, 2001).

Verbal communication in healthcare refers to the use of spoken or written language to convey information between healthcare professionals and patients. This includes providing clear, accurate, and culturally sensitive explanations about diagnoses, treatments, and procedures (Silverman, et al., 2013).

Nonverbal communication encompasses facial expressions, body language, eye contact, touch, proxemics (personal space), tone of voice, silence and other nonverbal cues that can significantly influence how messages are received and interpreted (Hall, 1976). In multicultural contexts, understanding cultural differences in nonverbal communication is crucial to avoid misunderstandings and build trust with patients from diverse backgrounds.

Team communication in multicultural healthcare settings refers to the exchange of information, ideas, and feedback among professionals from diverse cultural backgrounds. Effective team communication relies on cultural awareness, active listening, and conflict resolution strategies. According to Reeves, et al. (2010), highperforming multicultural teams demonstrate adaptability, mutual respect, and shared goals, which are critical for patient safety and care quality.

Barriers to effective communication include language differences, cultural misunderstandings, and misinterpretation of non-verbal cues (Samovar, et al., 2017).

Commitment to dialogue and collaboration involves the willingness of individuals and groups to engage in open, mutual dialogue and strive for joint solutions that are based on respect for cultural diversity and trust. It emphasizes the importance of fostering relationships through shared understanding and cooperation (Buber, 1970; Isaacs, 1999). **Building trust in multicultural environments** requires honesty, respect, and consistency in actions and communication (Ting-Toomey & Chung, 2012).

Dialogic approaches are essential for understanding diverse perspectives. Two-way communication, which involves active listening and an openness to other viewpoints, strengthens dialogue and fosters shared understanding (Bakhtin, 1981).

Collaborative practices further support commitment by engaging stakeholders in decision-making processes and co-creating solutions that integrate and respect diverse cultural insights. **Engaging stakeholders** ensures their active participation and consideration of their cultural values (Freeman, 2010), while co-creating solutions emphasizes the integration of diverse viewpoints to address common challenges (Gray, 1989).

Conflict resolution in multicultural settings is an essential component of collaboration. Effective strategies include mediation based on mutual respect and collaboration, with a focus on identifying shared values to resolve disputes constructively (Deutsch, et al., 2011).

9.2. Intercultural Communication in Healthcare

9.2.1. Theoretical Models of Intercultural Communication

Theoretical models in multicultural communication are increasingly applied to healthcare to address disparities in patient outcomes caused by cultural differences. These disparities often arise from misaligned expectations between patients and healthcare providers, language barriers, and differing cultural beliefs about health and illness. Research highlights that **culturally competent communication** can bridge these gaps, fostering better understanding and collaboration between providers and patients. This approach improves trust, which is foundational for effective therapeutic relationships, increases adherence to treatment plans by aligning care with the patient's cultural values, and enhances overall patient satisfaction by creating a more inclusive and respectful healthcare expe-

rience. Models such as the **Cultural competence continuum** emphasize that cultural competence is not a static achievement but a dynamic, ongoing process. The continuum includes several stages: cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence, cultural competence, and cultural proficiency. Healthcare providers are encouraged to move beyond basic cultural awareness, which involves simply recognizing cultural differences, to cultural proficiency. At this level, providers actively incorporate cultural knowledge and understanding into their communication and practice, ensuring that care is tailored dynamically to each patient's unique cultural background (Campinha- Bacote, 2002). Researchers agree that culturally competent communication is not limited to interactions between providers and patients but also extends to organisational practices within healthcare systems. Institutions are encouraged to create policies and frameworks that support cultural competence at all levels. This includes hiring staff from diverse cultural backgrounds, providing regular training on intercultural communication, and ensuring access to professional interpreters and culturally appropriate educational materials. This **systemic approach** complements the individual efforts of healthcare providers and fosters an environment where culturally appropriate care is the norm. In practice, culturally competent communication creates opportunities for shared decision making in which patients feel empowered to express their preferences and concerns. This **participatory approach** not only improves patient outcomes but also reduces the likelihood of misunderstanding and conflict. For example, studies have shown that patients are more willing to adhere to prescribed treatments when healthcare providers take the time to understand and integrate cultural beliefs about traditional healing practices, incorporating their preferred cultural remedies. This **holistic approach** demonstrates respect for the patient's cultural identity and builds trust and co-operation in the treatment process (Campinha-Bacote, 2002).

9.2.2. Challenges of Linguistic and Cultural Barriers

Language differences remain a critical barrier in healthcare communication. Patients with limited proficiency in the dominant language often experience lower quality of care due to miscommunication, misunderstanding, or inadequate explanations of their medical conditions and treatment options. This can lead to decreased patient satisfaction, reduced adherence to treatment plans, and worse health outcomes. For instance, studies have shown that language barriers can contribute to higher rates of hospital readmissions, medication errors, and delays in receiving care (Flores, 2006). Patients with limited English proficiency (LEP) often face challenges in accessing healthcare services, receive lower quality care, and experience poorer health outcomes. LEP is an independent factor contributing to health disparities and it could exacerbate the negative impact of other social determinants of health (Schwei, et al., 2016; American Medical Association, 2021). Furthermore, the stress and anxiety caused by an inability to communicate effectively with healthcare providers often exacerbate patients' conditions, particularly in urgent or emergency settings (Ulrey & Amason, 2001; Paternotte, et al., 2015).

Professional medical interpreters improve communication by accurately conveying medical terminology and cultural nuances, reducing errors and fostering patient trust. However, access remains inconsistent due to financial, staffing, and logistical challenges, with facilities in smaller towns often relying on less personal remote interpreting methods (Pöchhacker, 2015).

Cultural barriers significantly impact healthcare communication, influencing beliefs, decision-making, and perceptions of treatment. Collectivist cultures, such as those in East Asia or Latin America, emphasize family involvement in healthcare decisions, which may delay care if consensus is lacking. Conversely, individualist cultures, like those in North America and Western Europe, prioritize autonomy, often viewing family involvement as intrusive (Hofstede, et al., 2010). Cultural beliefs about illness, such as spiritual or holistic interpretations, can shape patients' willingness to follow medical advice, with some prioritizing prayer or traditional remedies over conventional treatments. Misinterpreting these norms can lead to inappropriate treatment or inadequate pain management, undermining patient trust and care quality (Samovar, et al., 2017). Cultural variations in **attitudes toward pain and emotional expression** present significant challenges in healthcare. While some cultures value stoicism, others encourage vocalizing pain to ensure recognition. Misinterpreting these norms can lead to underestimation or overestimation of a patient's condition, resulting in suboptimal treatment. For instance, providers unaware of cultural tendencies to underreport pain may inadequately manage a patient's discomfort, leading to insufficient care (Samovar, et al., 2017).

9.2.3. Patient-Centered Communication in Multicultural Settings

Studies show that addressing linguistic and cultural barriers through cultural competence significantly improves healthcare outcomes. This includes employing professional interpreters, using culturally adapted materials, and engaging in continuous training to respect diverse norms (Flores, 2006; Samovar, et al., 2017). Research also highlights the effectiveness of patient-centred communication models, such as the **LEARN framework**, which guides healthcare professionals to Listen to patients' concerns, **Explain** their perspective, **Acknowledge** cultural differences, **Recommend** appropriate treatment, and **Negotiate** a mutually acceptable care plan. This structured approach fosters meaningful dialogue, validates patient perspectives, and aligns care plans with cultural values, ultimately creating a more inclusive and supportive healthcare environment (Samovar, et al., 2017).

Non-Verbal Communication in Cross-Cultural Healthcare

Non-verbal communication plays a critical role in healthcare interactions, particularly when language barriers exist. Eye contact, gestures, touch, and physical space preferences vary widely across cultures and can impact patient perceptions of care. Studies show that training providers to recognize and adapt to cultural variations in non-verbal communication improves the patient experience and builds trust (Samovar, et al., 2017; Ting-Toomey & Chung, 2012).

The Role of Technology in Cross-Cultural Healthcare Communication

Digital tools, including telemedicine and mobile health apps, offer promising solutions for addressing cultural and linguistic barriers in healthcare, particularly for underserved populations. Their effectiveness, however, relies on culturally sensitive design, with user interfaces and content tailored to literacy levels, technological familiarity, and cultural norms (Aceto, et al., 2018). Studies show that challenges include the **digital divide**, as low-income and areas of digital exclusion populations often lack access to necessary infrastructure, and privacy concerns, which may vary by culture and affect trust in these technologies. Addressing these issues requires investments in equitable infrastructure and culturally attuned healthcare policies (Lythreatis, et al., 2021).

9.3. Strategies for Effective Cultural Communication

Effective communication is fundamental to delivering high-quality healthcare, especially in culturally diverse environments. It ensures that healthcare providers can establish trust, understand patient needs, and deliver appropriate care. Healthcare professionals can use strategies to improve communication with patients and colleagues.

1. Active Listening

Active listening is the cornerstone of effective communication. It involves fully concentrating on what the speaker is saying, understanding their message, and responding thoughtfully.

2. Using Clear and Simple Language

Medical jargon can be confusing or intimidating to patients, especially those with limited health literacy. Simplifying language and avoiding technical terms ensures that patients understand their diagnosis, treatment options, and care instructions.

3. Being Culturally Sensitive

Cultural sensitivity involves recognizing and respecting the cultural beliefs, values, and practices of patients. In diverse healthcare settings, cultural sensitivity helps providers to avoid misunderstandings and provide care that aligns with the patient's cultural context.

4. Non-Verbal Communication

Non-verbal communication, such as facial expressions, gestures, and body language, plays a significant role in healthcare interactions. Providers must be mindful of their non-verbal cues and learn to interpret those of patients from different cultural backgrounds.

5. Building Trust and Rapport

Trust is essential in the patient-provider relationship. When patients trust their healthcare providers, they are more likely to share important information, adhere to treatment plans, and feel satisfied with their care.

Strategies for Effective Communication in Healthcare
1. *Active Listening*
2. *Using Clear and Simple Language*
3. *Being Culturally Sensitive*
4. *Non-Verbal Communication*
5. *Building Trust and Rapport*
6. *Using Technology to Support Communication*
7. *Encouraging Shared Decision-Making*
8. *Addressing Language Barriers*
9. *Providing Empathy and Emotional Support*

6. Using Technology to Support Communication

Digital tools, such as electronic health records (EHRs), telemedicine platforms, and patient portals, can enhance communication between healthcare providers and patients. These technologies facilitate the exchange of information, improve access to care, and allow for better patient engagement.

7. Encouraging Shared Decision-Making

Shared decision-making involves patients and providers working together to make healthcare decisions that align with the patient's preferences and values. This collaborative approach leads to improved patient satisfaction and better health outcomes.

8. Addressing Language Barriers

Language barriers can impede effective communication, leading to misdiagnoses, medication errors, and reduced patient satisfaction. Overcoming these barriers is critical for ensuring equitable healthcare delivery.

9. Providing Empathy and Emotional Support

Empathy is the ability to understand and share the feelings of another person. In healthcare, showing empathy fosters a strong patient-provider relationship and helps patients feel supported during stressful times.

9.3.1. Active Listening in a Multicultural Context for Healthcare Professionals

Active listening is a fundamental communication skill for healthcare professionals, especially in multicultural contexts. In diverse healthcare environments, effective listening goes beyond merely hearing words; it requires understanding cultural nuances, acknowledging emotions, and demonstrating respect for the patient's perspective.

Active listening in multicultural contexts involves several key components:

1. Attentiveness

- Maintain eye contact (where culturally appropriate) and focus on the patient without distractions.
- Use body language, such as nodding or leaning slightly forward, to show engagement.
- Avoid interrupting or finishing the patient's sentences.

2. Clarification

- Ask open-ended questions to encourage patients to elaborate on their concerns (e.g., "Can you tell me more about what you're experiencing?").
- Request clarification when necessary to ensure understanding (e.g., "What do you mean when you say you feel 'heavy'?").

3. Reflection

- Paraphrase the patient's statements to confirm understanding (e.g., "So, you're saying that the pain is worse in the evenings?").
- Reflect on the patient's emotions to show empathy (e.g., "It sounds like this has been very frustrating for you.").

4. Empathy

- Demonstrate understanding of the patient's feelings and cultural perspective.
- Validate the patient's emotions (e.g., "I can see how this situation would make you feel anxious.").

5. Summarization

- Summarize the key points of the conversation to ensure that both parties are on the same page.
- Confirm next steps and any follow-up actions.

Cultural differences can influence how patients communicate their needs and respond to healthcare providers. Being aware of these differences is essential for effective active listening in multicultural contexts.

Strategies for Culturally Sensitive Active Listening:

- Be mindful of non-verbal cues, such as facial expressions, gestures, and tone of voice, which may vary across cultures.
- Adapt your communication style to match the patient's preferences (e.g., being more formal or informal depending on the cultural context).
- Avoid making assumptions based on stereotypes; treat each patient as an individual.

Examples of Cultural Influences on Communication:

- **High-Context vs. Low-Context Cultures:** In high-context cultures (e.g., Japan, China), communication often relies on implicit messages and non-verbal cues. In low-context cultures (e.g., the United States, Germany), communication tends to be more direct and explicit.
- **Attitudes Toward Authority:** In some cultures, patients may be hesitant to question or disagree with healthcare providers, viewing them as authority figures. Active listening can help create a safe space for these patients to voice their concerns.
- **Expression of Pain and Emotions:** Cultural norms can affect how patients describe their symptoms or express their emotions. For example, some cultures may discourage overt expressions of pain, while others may encourage vivid descriptions.

Healthcare professionals may encounter challenges when practicing active listening in multicultural contexts:

- Time Constraints: Limited time during consultations can make it difficult to listen actively.
- Implicit Bias: Unconscious biases may affect how providers perceive and respond to patients.
- Language Barriers: Even with interpreters, subtle nuances in language may be lost.
- Emotional Stress: Providers may feel overwhelmed by the emotional demands of listening to patients' concerns.

Overcoming These Challenges:

- Prioritize active listening for complex or sensitive cases, even if time is limited.
- Reflect on personal biases and seek cultural competence training to minimize their impact.
- Use checklists or communication frameworks, such as the LEARN model (Listen, Explain, Acknowledge, Recommend, Negotiate), to guide interactions.
- Practice self-care to manage stress and maintain emotional resilience.

9.3.2. Using Clear and Simple Language in a Multicultural Healthcare Context

To communicate effectively, healthcare professionals should adopt the following principles:

1. **Avoid Medical Jargon:** Use everyday terms instead of technical language. For example, say "high blood pressure" instead of "hypertension."
2. **Be Direct and Specific:** Avoid vague statements. Instead of saying, "You might need to take this," say, "Take this medication once a day after meals."
3. **Use Short Sentences:** Break complex ideas into smaller, more digestible parts. For instance, instead of, "The medication is for reducing inflammation, which helps alleviate pain and swelling," say, "This medicine reduces swelling and pain."
4. **Incorporate Visual Aids:** Use diagrams, charts, or pictures to explain procedures or conditions when possible.
5. **Ask for Feedback:** Confirm understanding by asking the patient to repeat the information in their own words.
6. **Speak at a Comfortable Pace:** Speak slowly and clearly, especially if the patient's first language differs from yours.

Strategies for Multicultural Communication

- Learn Key Phrases: Knowing basic words in the patient's language, like "pain," "medication," or "help," can make a big difference.
- Be Aware of Cultural Norms: Understand that cultural backgrounds influence how patients view healthcare, express symptoms, and interact with profes-

sionals. For example, in some cultures, patients may be reluctant to ask questions or voice concerns.
- Use Professional Interpreters: When language barriers are significant, use trained interpreters rather than relying on family members, who might lack medical knowledge or add personal biases.
- Be Patient and Open-Minded: Give patients time to process information and ask questions. Avoid making assumptions about their understanding or preferences.
- Acknowledge Non-Verbal Cues: Body language, facial expressions, and tone of voice can provide valuable insight into whether a patient understands or feels comfortable.

9.3.3. Being Culturally Sensitive in a Multicultural Healthcare Setting

Cultural sensitivity involves recognizing, respecting, and valuing cultural differences. It goes beyond mere awareness to actively adapt communication, behaviours, and care plans to meet patients' cultural needs. Healthcare professionals must understand that culture affects how individuals interpret symptoms, seek care, adhere to treatments, and perceive healthcare systems.

Principles of Cultural Sensitivity

- Self-awareness: Reflect on your cultural biases, values, and assumptions. Recognizing personal preconceptions helps you avoid imposing them on patients.
- Cultural Knowledge: Learn about common cultural beliefs and practices relevant to your patient population. While generalizations can provide context, remember that each patient is unique.

Practical Example

Scenario: A patient from a different cultural background arrives with symptoms of diabetes but struggles to understand medical terms.

- Use Clear Language: Instead of saying, *"Your glucose levels indicate hyperglycemia,"* say, *"Your blood sugar is too high."*
- Visual Aid: Show a chart with normal and high blood sugar levels.
- Feedback: Ask, *"Can you tell me what you understand about your blood sugar levels?"*
- Cultural Sensitivity: If the patient's diet is culturally specific, discuss foods that align with their traditions but also support their health.

- Empathy and Respect: Approach every patient's interaction with empathy, seeking to understand their perspectives and showing respect for their values and preferences.
- Effective Communication: Use clear, jargon-free language. When necessary, work with interpreters to ensure accurate understanding.
- Adaptability: Be flexible and willing to modify your approach to align with a patient's cultural context.

Practical Strategies for Culturally Sensitive Care

1. Building Trust:

- Begin by introducing yourself and explaining your role.
- Show genuine interest in the patient's background and preferences.
- Use active listening techniques, such as maintaining eye contact (if culturally appropriate) and nodding.

2. Understanding Cultural Beliefs About Health:

- Ask open-ended questions to uncover cultural beliefs about illness and treatment. For example, "How do you view your illness?" or "Are there any traditional practices you follow?"
- Respect traditional healing practices and, where possible, integrate them with biomedical treatments.

3. Addressing Language Barriers:

- Use professional interpreters rather than relying on family members, as this ensures accuracy and maintains patient confidentiality.
- Provide written materials in the patient's preferred language.
- Learn key phrases in the languages commonly spoken by your patients.

4. Navigating Cultural Differences:

- Be aware of cultural norms related to gender roles, modesty, and physical touch. For instance, some patients may prefer a healthcare provider of the same gender.
- Understand cultural variations in expressions of pain, grief, or emotions.
- Avoid making assumptions based on stereotypes; ask patients about their preferences.

5. Encouraging Patient Participation:

- Involve patients and their families in decision-making processes, as family dynamics play a significant role in many cultures.
- Explain treatment options clearly, ensuring patients understand and feel empowered to make choices.

Challenges and How to Overcome Them

- Time Constraints: Allocating extra time for culturally sensitive care may be challenging. Prioritize building rapport early to streamline future interactions.
- Lack of Cultural Knowledge: Stay informed through training, workshops, and resources on cultural competence.
- Implicit Bias: Use tools like implicit association tests to identify and mitigate unconscious biases.

Being culturally sensitive is fundamental to delivering high-quality care in a multicultural healthcare setting. It requires ongoing self-reflection, learning, and adaptability. By understanding and respecting patients' cultural backgrounds, healthcare professionals can build trust, improve health outcomes, and ensure that every patient feels valued and cared for. Cultural sensitivity is not just about providing treatment—it's about fostering a healing relationship grounded in mutual respect and understanding.

9.3.4. Non-Verbal Communication

Non-verbal communication constitutes a significant portion of human interaction, often supplementing or even replacing verbal communication. In healthcare, it becomes particularly important when language barriers exist. For example, a smile or a nod can reassure a patient, even if they do not understand the spoken language. Similarly, observing a patient's body language, such as signs of discomfort or anxiety, can alert healthcare professionals to unspoken concerns.

Non-verbal communication can be divided and applied in healthcare:

Facial Expressions

Importance: Facial expressions convey emotions such as empathy, concern, and understanding.

In Practice:
- *A warm smile can put patients at ease.*
- *Avoiding expressions of frustration or disapproval can help maintain trust.*
- *Use gentle and encouraging expressions*
- *when delivering sensitive information.*

Eye Contact

Importance: Eye contact demonstrates attentiveness and respect, making patients feel heard and valued.

In Practice:
- *Maintain appropriate eye contact without staring, as this can feel intimidating.*
- *Be mindful that in some cultures, prolonged eye contact is considered disrespectful.*

Body Language

Importance: Body posture, gestures, and movement reflect engagement and openness.

In Practice:

- *Lean slightly forward to show attentiveness.*
- *Avoid crossing arms, which may be perceived as defensive or closed off.*
- *Use open hand gestures to reinforce spoken messages.*

Proxemics (Personal Space)

Importance: Respecting personal space is essential to making patients feel comfortable.

In Practice:

- *Maintain an appropriate distance based on the patient's comfort level and cultural norms.*
- *Recognize that some patients may prefer more space, while others may feel reassured by closeness.*

Touch

Importance: Touch can convey empathy, support, and reassurance, especially in emotional or critical situations.

In Practice:

- *Use a gentle touch on the shoulder or hand to comfort patients, but always be mindful of cultural boundaries or personal preferences.*
- *Avoid unnecessary or excessive physical contact, which*

Tone of Voice (Paralinguistics)

Importance: The tone, pitch, and pace of speech can influence how messages are received.

In Practice:

- *Use a calm and steady tone to create a sense of safety and trust.*
- *Avoid sounding rushed or dismissive, as this may make patients feel unimportant.*
- *Slow down when explaining complex medical information.*

Gestures

Importance: Hand movements and gestures can clarify or emphasize verbal communication.

In Practice:

- *Use simple, clear gestures to explain procedures or concepts.*
- *Be cautious about using gestures that may have different meanings in other cultures.*

Silence

Importance: Silence can provide space for patients to process information and feel comfortable sharing their thoughts.

In Practice:

- *Allow moments of silence during difficult conversations.*
- *Use silence strategically to encourage patients to speak without feeling rushed.*

Appearance and Professionalism

Importance: A healthcare provider's appearance conveys competence and credibility.

In Practice:

- *Maintain a clean, professional look that aligns with workplace standards.*
- *Wear identification badges prominently to help patients feel secure.*

Cultural Sensitivity in Non-Verbal Communication

Importance: Cultural differences can significantly influence the interpretation of non-verbal cues.

In Practice:

- *Be aware of cultural norms regarding eye contact, touch, and personal space.*
- *When unsure, observe the patient's cues and adjust accordingly.*

Integrating Non-Verbal Communication into Practice:

- *Self-Awareness*: Regularly assess your non-verbal behaviors to ensure they align with your intended message.
- *Patient Observation*: Pay attention to patients' non-verbal cues, such as body language or facial expressions, to better understand their feelings and concerns.
- *Consistency*: Ensure that your non-verbal communication complements your verbal messages for clarity and trust.

Cultural Variations in Non-Verbal Communication

Non-verbal cues are not universal; they vary widely across cultures. A gesture or facial expression that conveys one meaning in one culture may have a completely different or even opposite meaning in another. For instance:

- *Eye Contact:* In Western cultures, maintaining eye contact often signifies attentiveness and honesty. However, in some Asian or Middle Eastern cultures, prolonged eye contact may be considered disrespectful or confrontational.
- *Touch:* In many Western countries, a gentle touch on the arm can convey empathy. However, in other cultures, physical touch may be inappropriate, especially between genders.
- *Gestures:* Hand gestures, such as a thumbs-up or an okay sign, are positive in some cultures but offensive in others.
- *Personal Space:* Cultures vary in their norms regarding personal space. While North Americans may prefer a larger personal distance, people from Latin American or Mediterranean cultures may feel more comfortable standing closer.

Understanding these differences is essential for healthcare professionals to avoid miscommunication and unintentional offense.

Observing and Interpreting Non-Verbal Cues

Healthcare providers must develop strong observational skills to interpret non-verbal cues accurately. For example:

- *Facial Expressions:* A patient's expression can reveal pain, confusion, or fear even if they do not verbalize it.
- *Posture and Movement:* A slouched posture may indicate fatigue or depression, while fidgeting could signify anxiety.
- *Paralanguage:* Tone, pitch, and pace of speech, even in a language the provider does not understand, can provide insight into a patient's emotional state.

Adapting Non-Verbal Communication to Multicultural Contexts

To ensure effective communication, healthcare professionals should adapt their nonverbal behaviour according to the patient's cultural background:

- *Cultural Sensitivity Training:* Regular training sessions can help staff understand cultural norms and avoid common pitfalls.

- *Patient-Centered Approach:* Observing the patient's comfort levels and mirroring their non-verbal cues can help establish rapport.
- *Using Visual Aids:* Diagrams, pictures, or videos can overcome language barriers and ensure patients understand instructions or procedures.

9.3.5. Building Trust and Rapport in Multicultural Healthcare Communication

Trust is the foundation of any patient-provider relationship. It is cultivated when patients feel that their healthcare providers are competent, empathetic, and respectful of their needs. Rapport, on the other hand, involves creating a positive connection through mutual understanding and effective communication. Together, trust and rapport help reduce anxiety, improve patient satisfaction, and encourage active participation in healthcare decisions.

Challenges in Multicultural Settings

Building trust in multicultural contexts presents unique challenges. These may include:

- *Language Barriers:* Limited proficiency in the dominant language can hinder clear communication, leading to misunderstandings.
- *Cultural Differences:* Variations in values, beliefs, and practices can affect perceptions of illness, treatment, and healthcare professionals.
- *Past Experiences:* Patients from marginalized or minority communities may bring a history of distrust toward medical systems due to discrimination or unequal treatment.

Overcoming these challenges requires healthcare providers to adopt culturally sensitive communication strategies.

Strategies for Building Trust and Rapport

Building trust and rapport in multicultural healthcare settings requires cultural competence, empathy, active listening, and clear communication. Overcoming challenges such as language barriers and cultural differences is crucial for creating a positive patient experience. By developing these skills and practicing effective communication strategies, healthcare professionals can ensure equitable and compassionate care for all patients, regardless of their background.

9.3.6. Using Technology to Support Communication in Multicultural Healthcare

Technology has revolutionized healthcare communication, making it possible to connect with patients from various linguistic and cultural backgrounds. Tools such as mobile apps, video conferencing, and electronic health records (EHRs) not only improve communication but also help healthcare professionals provide culturally appropriate care. In multicultural settings, technology can:

- Facilitate real-time language translation.
- Provide visual aids to explain medical concepts.
- Enhance patient education with accessible and culturally relevant materials.

Key Technologies Supporting Multicultural Communication

There are several technologies that healthcare professionals can use to overcome communication barriers in multicultural settings:

- *Translation and Interpretation Apps:*
  - Applications like Google Translate, MediBabble, and Care to Translate are designed for medical use and support healthcare providers in translating medical terms and phrases.
  - While these tools are helpful, it's important to validate translations, especially for complex or sensitive medical information.
- *Telehealth Platforms:*
  - Telehealth services often include integrated interpretation features, allowing patients and providers to communicate through live interpreters or video captions.
  - Video consultations with culturally matched interpreters can improve patient comfort and trust.
- *Electronic Health Records (EHRs):*
  - EHR systems can store patient preferences, including language, cultural considerations, and religious beliefs, enabling providers to tailor their care approach.
  - These systems can also integrate decision-support tools that recommend culturally sensitive care practices.
- *Patient Education Tools:* Multimedia platforms, such as videos, infographics, and interactive software, help explain medical procedures, diagnoses, and treatments in a patient's preferred language and culturally appropriate context.
- *Wearable Devices and Health Apps:* Devices that track health metrics, combined with multilingual apps, can help patients from diverse backgrounds manage chronic conditions while receiving prompts and education in their own language.

Benefits of Technology in Multicultural Communication

Using technology to support communication offers several benefits in multicultural healthcare:

- Improved Patient Understanding: Patients are more likely to understand their diagnosis and treatment plans when information is provided in their native language.
- Enhanced Efficiency: Technology reduces the time spent on resolving misunderstandings and improves workflow efficiency.
- Better Patient Engagement: Culturally relevant and language-specific tools encourage patients to actively participate in their care.
- Equitable Access: Technology enables underserved communities to access healthcare services, including those in remote or rural areas.

Challenges and Limitations

While technology offers significant advantages, it is not without challenges:

- Accuracy of Translation Tools: Automated translation apps may not always provide accurate translations, particularly for complex medical terminology.
- Digital Divide: Not all patients have access to the internet or are comfortable using digital devices, creating disparities in healthcare access.
- Privacy Concerns: The use of technology in healthcare must comply with strict privacy and data security regulations to protect patient information.
- Cultural Sensitivity: Even with translation tools, culturally nuanced communication requires human interpretation and understanding.

Best Practices for Using Technology in Multicultural Communication

To maximize the benefits of technology, healthcare professionals should follow these best practices:

- **Combine Technology with Human Interaction:** Use translation apps and telehealth services as supplements to professional interpreters and culturally trained staff.
- **Test and Validate Tools:** Regularly evaluate the accuracy and reliability of technology to ensure it meets medical communication standards.
- **Provide Training:** Train healthcare providers and patients in using communication technologies effectively.
- **Focus on Accessibility:** Choose tools that are user-friendly, compatible with multiple languages, and accessible to patients with varying levels of digital literacy.
- **Maintain Cultural Competence:** Ensure that technology supports, rather than replaces, the need for culturally aware and empathetic communication.

9.3.7. Encouraging Shared Decision-Making in Multicultural Healthcare Communication

Shared decision-making involves three essential components: providing the patient with information about their condition and treatment options, discussing the potential risks and benefits of each option, and incorporating the patient's preferences into the final decision.

Fig.12. Components of shared decision-making

This collaborative approach respects patient autonomy while ensuring they are supported in making choices that align with their values and cultural beliefs.

Barriers to Shared Decision-Making in Multicultural Contexts

Several challenges may arise when promoting SDM in a multicultural environment:

- *Language Barriers:* Limited proficiency in the local language can hinder effective communication. Patients may struggle to understand medical terms or express their concerns, leading to potential misunderstandings.
- *Health Literacy:* Variations in health literacy levels across cultural groups can impact patients' ability to comprehend complex medical information, making SDM more challenging.
- *Cultural Misunderstandings:* Cultural differences in communication styles, nonverbal cues, and attitudes toward authority can create misunderstandings or discomfort during interactions.
- *Implicit Bias:* Healthcare providers' unconscious biases may affect how they present information or engage with patients from different cultural backgrounds.

Strategies to Encourage Shared Decision-Making

To address these challenges and promote SDM, healthcare professionals can adopt the following strategies:

1. *Build Cultural Competence:* Developing cultural awareness and understanding helps providers recognize and respect patients' values and beliefs. This can be achieved through cultural competency training and continuous learning.
2. *Use Interpreters and Visual Aids:* Professional interpreters and culturally appropriate visual aids can bridge language gaps and ensure patients fully understand their options.
3. *Simplify Medical Information:* Presenting information in plain language, avoiding medical jargon, and using metaphors or analogies that resonate with the patient's cultural background can enhance comprehension.
4. *Adopt Active Listening:* Demonstrating empathy, asking open-ended questions, andallowing patients to share their thoughts without interruption fosters trust andencourages participation.
5. *Involve Family Members:* In cultures where family plays a central role in decisionmaking, involving key family members can facilitate discussions and respect cultural norms.
6. *Encourage Questions and Feedback:* Actively inviting patients to ask questions or express concerns creates a safe space for dialogue and helps clarify uncertainties.
7. *Tailor Decision-Making Approaches:* Flexibility in adapting decision-making processes to align with the patient's cultural expectations can lead to better outcomes.

9.3.8. Addressing Language Barriers in Multicultural Healthcare Communication

Language barriers can lead to misunderstandings between patients and healthcare providers, potentially resulting in incorrect diagnoses, inappropriate treatments, or reduced adherence to medical advice. For example, a patient who cannot fully understand a doctor's instructions might unintentionally mismanage their medication. Furthermore, the inability to communicate effectively can cause patients to feel alienated or neglected, undermining trust in the healthcare system. This highlights the need for strategies to bridge communication gaps.

Strategies for Overcoming Language Barriers

1. Use of Professional Medical Interpreters

Professional interpreters play a vital role in facilitating accurate communication between healthcare providers and patients who speak different languages. Unlike family members or friends, interpreters are trained to maintain confidentiality, avoid personal biases, and understand medical terminology. Employing interpreters ensures that patients receive precise information about their condition and treatment.

However, it is important to ensure the availability of interpreters across various languages and in real-time, as delays can affect critical decision-making.

2. **Translation of Written Materials**

Providing translated versions of consent forms, patient education materials, and medication instructions can help patients better understand their treatment plans. These materials should be written in plain language and culturally adapted to ensure clarity and relevance. Utilizing visual aids, such as diagrams and illustrations, can further enhance understanding for patients with limited literacy in their native language.

3. **Training Healthcare Professionals**

Healthcare workers should be trained in cross-cultural communication and basic language skills relevant to the patient population they serve. While fluency in multiple languages may not be feasible, learning key phrases or medical terms in common languages can foster better rapport with patients. Moreover, training programs should emphasize active listening skills and nonverbal communication techniques, such as maintaining eye contact and using gestures to clarify information.

4. **Leveraging Technology**

Advancements in technology offer innovative solutions to address language barriers. Language translation apps and devices can provide real-time translations, assisting healthcare providers in communicating with patients. However, these tools should be used with caution, as automated translations may lack contextual accuracy. Virtual interpreter services, accessible through video calls, are another effective option for overcoming language challenges in healthcare settings.

5. **Encouraging Community Engagement**

Building partnerships with local communities can help healthcare institutions better understand the linguistic and cultural needs of their patients. Engaging community leaders and organizations can facilitate the development of culturally tailored health promotion programs and provide insights into overcoming specific language-related challenges.

9.3.9. Providing Empathy and Emotional Support in Multicultural Healthcare Communication

Empathy involves recognizing, understanding, and sharing the feelings of another person. In a multicultural context, it requires healthcare providers to go beyond their own cultural frameworks and appreciate the perspectives and experiences of patients from diverse backgrounds. This process includes acknowledging the cultural factors that influence a patient's emotions, such as their beliefs about health, family dynamics, and expressions of distress. For example, some cultures may view illness as a communal issue rather than an individual problem, requiring healthcare professionals to engage with family members as part of the care process. Similarly, certain cultures may express emotional distress nonverbally or minimize their symptoms to avoid appearing burdensome. Recognizing these cultural nuances is vital to providing empathetic and effective care.

Strategies for Demonstrating Empathy and Emotional Support

1. **Active Listening** (see Chapter: Active Listening in a Multicultural Context for Healthcare Professionals)
2. **Nonverbal Communication** (see Chapter: Non-Verbal Communication in Multicultural Healthcare Settings)
3. **Cultural Sensitivity in Emotional Responses**

Cultural norms influence how individuals express and interpret emotions, which can impact patient-provider interactions. Being culturally sensitive to these differences helps ensure patients feel understood and respected. In some cultures, openly expressing emotions is encouraged, while in others, it is considered inappropriate or a sign of weakness. Recognizing these variations allows healthcare providers to adapt their responses accordingly.

For example, instead of assuming silence indicates indifference, phrases like "I want to make sure I understand how you're feeling" or "It's okay to share as much or as little as you're comfortable with" demonstrate empathy while respecting cultural norms.

4. **Validating Emotions**

Patients may feel vulnerable or anxious, especially when dealing with unfamiliar healthcare systems or serious health conditions. Validating their emotions—acknowledging their fears, frustrations, or sadness without judgment—can help reduce their stress.

Phrases like "It's understandable to feel this way" or "I can see how this is upsetting for you" show empathy and reassure the patient that their emotions are normal and accepted.

5. **Providing Culturally Appropriate Emotional Support**

Emotional support should align with the patient's cultural values and beliefs. For example, in collectivist cultures, involving family members in discussions about care may provide significant emotional comfort. Alternatively, in cultures where privacy is highly valued, offering one-on-one discussions in a private setting may be more appropriate.

9.4. Commitment to Dialogue and Collaboration in Multicultural Healthcare Communication

Commitment to Dialogue and Collaboration

- *Dialogic Approaches: The role of open, two-way communication in understanding diverse perspectives.*
- *Collaborative Practices:*
  - *Engaging stakeholders in decision-making processes.*
  - *Co-creating solutions that respect and integrate cultural values.*
- *Conflict Resolution: Strategies for managing cultural conflicts through mediation and mutual respect.*

Dialogic communication emphasizes open, twoway interactions where all parties actively listen, share perspectives, and seek mutual understanding. In healthcare, this approach goes beyond traditional, one-sided messages, ensuring that patients feel heard and respected.

Principles of Dialogic Communication: active listening, cultural awareness, clarification and reflection

Collaboration in healthcare requires the active involvement of all stakeholders—patients, families, caregivers, and healthcare providers—in the decision-making process. When dealing with diverse populations, collaboration must integrate cultural values and respect individual preferences.

Engaging stakeholders in decision-making is conditioned by inclusive participation, transparency, and flexibility. Collaborative healthcare requires co-creating solutions that balance clinical best practices with cultural values. This approach fosters shared responsibility and ensures that care plans are practical and culturally acceptable.

Cultural conflicts in healthcare arise when differing values, beliefs, or practices lead to misunderstandings or disagreements. Effective conflict resolution strategies involve mediation, empathy, and mutual respect.

Strategies for Conflict Resolution:

- Understanding the Root Cause
- Mediation
- Focusing on Shared Goals
- Demonstrating Empathy and Respect

9.4.1. Dialogic Approaches: The Role of Open, Two-Way Communication in Multicultural Healthcare

Dialogic communication is an essential skill in multicultural healthcare, promoting open, two-way interactions that prioritize understanding, empathy, and collaboration. Unlike traditional one-sided exchanges where the healthcare provider dominates the conversation, dialogic approaches encourage active participation from both the patient and provider. These foster trust and ensure that the patient's values, beliefs, and needs are understood and respected.

In multicultural healthcare settings, where cultural, linguistic, and social differences can create barriers, dialogic communication is particularly valuable. It helps bridge gaps, mitigate misunderstandings, and support patient-centred care by enabling meaningful dialogue.

Principles of Dialogic Communication

1. **Active Listening**
   - Active listening is a cornerstone of dialogic communication, requiring the healthcare provider to focus fully on the patient's words, emotions, and nonverbal cues.

What it entails: Listening without interruption, maintaining eye contact (when culturally appropriate), and acknowledging the patient's perspective.

Benefits: This approach helps patients feel validated and understood, encouraging them to share more openly about their concerns and experiences.

Example: A patient might describe a symptom using culturally specific terms or metaphors. Active listening allows the provider to recognize the underlying meaning and ask follow-up questions to clarify.

2. **Cultural Awareness**
   - Cultural awareness ensures that dialogic communication is sensitive to the patient's cultural values, beliefs, and communication norms.
   - **What it entails:** Understanding that different cultures have diverse ways of expressing emotions, asking questions, or discussing health-related topics. Providers must adapt their communication style to align with the patient's cultural context.

- **Benefits:** Cultural awareness minimizes misunderstandings and helps build rapport, especially in situations where cultural norms might influence a patient's decision-making or openness.
- **Example:** In some cultures, patients may avoid direct disagreement with authority figures like doctors. Recognizing this, a provider can ask open-ended questions like, "What are your thoughts about this treatment plan?" instead of seeking direct agreement.

3. **Clarification and Reflection**
   - Clarification and reflection involve summarizing and paraphrasing the patient's words to ensure mutual understanding.
   - **What it entails:** Asking clarifying questions and reflecting back what the patient has said to confirm accuracy. For example, "*If I understand correctly, you're saying that the pain gets worse after meals. Is that right?*"
   - **Benefits:** This process prevents misinterpretation, particularly when language barriers or cultural differences might obscure the meaning. It also demonstrates to the patient that their concerns are being taken seriously.
   - **Example:** Patients from a different linguistic background may use phrases or idioms unfamiliar to the provider. Reflecting on their statements helps both parties align their understanding.

Strategies for Implementing Dialogic Communication

1. **Encourage Patient Participation**
   - Ask open-ended questions to invite the patient to share their experiences and concerns.
   - Example: "*Can you tell me more about how this condition is affecting your daily life?*"

2. **Adapt Communication Styles**
   - Modify your tone, pace, and vocabulary to suit the patient's language proficiency and cultural norms. Avoid medical jargon and use visual aids or translators when needed.

3. **Build Trust and Rapport**
   - Show genuine interest in the patient's perspective. Acknowledge their emotions and emphasize collaboration in the decision-making process.

4. **Involve Family Members When Appropriate**
   - In many cultures, healthcare decisions involve family members. Engaging them in the dialogue can enhance understanding and support the patient's comfort and decision-making.

5. **Provide Continuous Feedback**
   - Let the patient know that their input is valued. Use affirming language and gestures to show appreciation for their openness.

Challenges and Solutions in Multicultural Settings

- **Language Barriers:** Use professional interpreters or translation tools to ensure clear communication.
- **Benefits:** Cultural awareness minimizes misunderstandings and helps build rapport, especially in situations where cultural norms might influence a patient's decision-making or openness.
- **Example:** In some cultures, patients may avoid direct disagreement with authority figures like doctors. Recognizing this, a provider can ask open-ended questions like, "What are your thoughts about this treatment plan?" instead of seeking direct agreement.

9.4.2. Collaborative Practices in Multicultural Healthcare

Collaboration in healthcare is essential for delivering patient-centred care, particularly in multicultural contexts. It involves the active participation of all stakeholders—patients, families, caregivers, and healthcare providers—in making decisions about treatment and care. For this collaboration to succeed in diverse populations, healthcare providers must integrate cultural values, respect individual preferences, and remain sensitive to unique needs. By fostering a partnership-based approach, healthcare professionals can ensure improved outcomes, enhanced trust, and greater patient satisfaction.

Engaging Stakeholders in Decision-Making

Effective collaboration in multicultural healthcare begins with actively engaging all stakeholders in the decision-making process. This ensures that care plans are both clinically effective and culturally appropriate.

1. **Inclusive Participation**

Inclusive participation means involving all relevant parties in healthcare discussions. Patients and their families should feel empowered to express their preferences, cultural beliefs, and concerns. For example, in some cultures, family members play a significant role in decision-making and excluding them can lead to mistrust or noncompliance with treatment plans. Encouraging open dialogue and actively listening to the perspectives of all stakeholders can bridge cultural gaps and foster a sense of shared ownership in care.

2. **Transparency**

Transparency is a cornerstone of effective collaboration. Healthcare providers must communicate openly and clearly, ensuring that patients understand their diagnoses, treatment options, and the risks and benefits involved. In multicultural settings, it is crucial to consider language differences and literacy levels. Using interpreters, visual aids, and simple language can improve understanding and help patients feel more confident in their decisions.

3. **Flexibility**

Flexibility is essential when working with diverse populations. Cultural norms and values can significantly influence healthcare decisions. For instance, some patients may prefer alternative medicine or holistic approaches over conventional treatments. Rather than dismissing these preferences, healthcare providers should adopt a flexible approach that incorporates these methods where safe and feasible. This adaptability not only respects the patient's cultural background but also strengthens the therapeutic relationship.

Co-Creating Solutions

Collaborative healthcare involves co-creating solutions that balance clinical best practices with cultural values. This approach fosters shared responsibility and ensures that care plans are practical, acceptable, and culturally sensitive.

1. **Blending Clinical Practices with Cultural Values**

Co-creating solutions means finding a middle ground between evidence-based medical practices and the patient's cultural beliefs. For example, a patient from a culture that values herbal remedies may feel more comfortable incorporating these remedies into their care plan alongside prescribed medications. In such cases, healthcare providers can educate the patient about potential interactions or risks while respecting their preferences.

2. **Leveraging Multidisciplinary Teams**

In multicultural healthcare, a multidisciplinary approach can improve collaboration and outcomes. Teams that include physicians, nurses, social workers, cul-

tural mediators, and interpreters can address the diverse needs of patients more effectively. For example, a cultural mediator can provide insights into a patient's cultural background, helping the team develop a care plan that aligns with their values.

3. **Building Trust and Mutual Respect**

Trust is the foundation of any collaborative relationship. Healthcare providers can build trust by showing empathy, being nonjudgmental, and validating the patient's concerns. Mutual respect ensures that patients feel valued and understood, leading to better adherence to treatment plans and a stronger therapeutic alliance.

9.4.3. Conflict Resolution: Managing Cultural Conflicts in Healthcare

Cultural diversity in healthcare is both a strength and a challenge. While it enriches the healthcare environment by bringing different perspectives and practices, it can also lead to misunderstandings, tensions, or outright conflicts. Cultural conflicts often arise when patients, families, or healthcare providers hold differing values, beliefs, or practices. For healthcare professionals, effectively managing such conflicts is critical to ensuring quality care, maintaining trust, and promoting an inclusive environment. This subsection outlines strategies for conflict resolution in multicultural healthcare communication, emphasizing understanding, mediation, shared goals, empathy, and respect.

Understanding the Root Cause of Cultural Conflicts

The first step in resolving any conflict is identifying its root cause. Cultural conflicts in healthcare often stem from differences in communication styles, healthcare expectations, religious beliefs, or traditional practices. For example, a patient from a culture that values holistic medicine might be reluctant to accept a purely biomedical approach. Similarly, a healthcare provider might misinterpret a patient's silence or nonverbal cues as disinterest, while it could simply reflect cultural norms of deference.

Steps to Understand the Root Cause:

- *Active Listening:* Allow all parties involved to express their perspectives without interruption. Active listening helps uncover underlying issues and demonstrates respect for differing viewpoints.
- *Cultural Awareness:* Educate yourself about the cultural backgrounds of the communities you serve. Understanding common beliefs or practices can help you anticipate and address potential conflicts.
- *Open-Ended Questions:* Ask questions that encourage patients or colleagues to share their thoughts and feelings. For example, instead of saying, "*Why won't you take this medication?*" ask, "*Can you tell me about your concerns with this treatment?*"

By understanding the root cause, healthcare providers can avoid making assumptions and approach the conflict with greater clarity and cultural sensitivity.

Mediation: Bridging Differences Through Neutral Facilitation

Mediation is a collaborative approach to conflict resolution that involves a neutral third-party facilitating dialogue between conflicting parties. In healthcare, this could be a cultural mediator, interpreter, or even a trusted staff member with training in conflict resolution.

Steps for Effective Mediation:

- *Create a Safe Environment:* Ensure all parties feel heard and respected. Choose a neutral, private space where participants can express their concerns without fear of judgment.
- *Clarify Misunderstandings:* Encourage each side to explain their perspective while identifying any miscommunications or false assumptions. For instance, if a family insists on certain rituals during a patient's care, the mediator can help the healthcare team understand the cultural or spiritual significance of these practices.
- *Seek Compromise:* The mediator facilitates discussions to find mutually acceptable solutions. This may involve adjusting treatment plans to accommodate cultural practices or educating patients and families about medical protocols.

Mediation helps to bridge cultural gaps by fostering mutual understanding and collaboration. It reduces hostility and creates a sense of shared responsibility for resolving the conflict.

Focusing on Shared Goals

In healthcare, the goal is the well-being of the patient. Conflicts often escalate because the parties involved focus on their differences rather than their shared objectives. Refocusing the conversation on shared goals can help de-escalate tensions and foster collaboration.

Steps to Focus on Shared Goals:

- *Define Common Objectives:* Remind everyone involved that the primary goal is to ensure the patient's health and safety. Highlight how working together can lead to better outcomes.
- *Emphasize Teamwork:* Frame the situation as a team effort where every individual's input is valuable. This shifts the focus from "us vs. them" to "we."
- *Set Clear Expectations:* Establish clear, achievable steps to resolve the conflict. For example, if a patient refuses a certain procedure due to cultural beliefs, discuss alternative treatments that align with their values while meeting medical requirements.

By concentrating on shared goals, healthcare providers can redirect energy from conflict toward constructive problem-solving.

Demonstrating Empathy and Respect

Empathy and respect are fundamental to conflict resolution. They help build trust and create an environment where individuals feel valued, regardless of cultural differences. Demonstrating empathy involves understanding and validating another person's feelings, while respect acknowledges their dignity and worth.

How to Demonstrate Empathy and Respect:

- *Acknowledge Emotions:* Recognize and validate the emotions of the individuals involved. For instance, say, "*I understand that this situation is very important to you, and I want to work with you to find a solution.*"
- *Adapt Your Communication Style:* Pay attention to verbal and nonverbal cues that reflect cultural norms. For example, some cultures prefer indirect communication, while others value directness.
- *Respect Cultural Practices:* Even if you cannot fully accommodate a cultural practice, showing willingness to understand and integrate it as much as possible demonstrates respect. For instance, allowing family members to be present during specific rituals can make patients feel supported.
- *Avoid Judgment:* Approach conflicts with curiosity and openness rather than judgment. Replace questions like, "*Why would you do that?*" with, "*Can you help me understand your perspective?*"

Empathy and respect help de-escalate conflicts by fostering a sense of connection and mutual understanding.

Key Takeaways for Healthcare Professionals

- *Cultural Competence is Essential: Educate yourself about the cultural backgrounds of your patients to anticipate potential conflicts.*
- *Communication is Key: Effective communication requires active listening, open-ended questions, and cultural awareness.*
- *Collaboration Yields Results: Engage patients, families, and colleagues as partners in care, emphasizing shared goals and mutual respect.*
- *Empathy and Respect Build Trust: Demonstrating genuine care and understanding creates a foundation for resolving conflicts constructively.*
- *Adaptability is Crucial: Be flexible in your approach, finding creative solutions to meet both medical and cultural needs.*

Practical Examples of Cultural Conflict Resolution in Healthcare

Case 1: Religious Beliefs and Medical Treatment

A patient refuses a blood transfusion due to religious beliefs. The healthcare provider feels the transfusion is necessary to save the patient's life.

Resolution: The provider consults a mediator to facilitate dialogue. Together, they explore alternative treatments, such as bloodless surgery or using blood substitutes, aligning medical care with the patient's beliefs.

Case 2: Family Involvement in Decision-Making

A healthcare provider insists on speaking directly to the patient about their condition, but the patient's culture prioritizes family involvement in medical decisions.

Resolution: The provider adapts their approach, including the family in discussions while ensuring the patient's autonomy is respected. They emphasize shared goals to balance cultural preferences with ethical medical practices.

Case 3: Traditional Healing Practices

A patient uses traditional remedies that the healthcare provider fears may interfere with prescribed medications.

Resolution: The provider discusses the patient's remedies and educates them on potential interactions, seeking a compromise that incorporates safe elements of traditional practices alongside medical treatment.

References

Aceto, G., Persico, V., & Pescapè, A. (2018). The role of Information and Communication Technologies in healthcare: Taxonomies, perspectives, and challenges. Journal of Network and Computer Applications, 107, 125–154.

American Medical Association. (2021). How should clinicians respond to language barriers that exacerbate health inequity? AMA Journal of Ethics, 23(2), E117–E124.

Bakhtin, M. M. (1981). The dialogic imagination. University of Texas Press.

Brownell, J. (2012). Listening: Attitudes, principles, and skills. Pearson.

Buber, M. (1970). I and Thou. Scribner.

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. Journal of Transcultural Nursing, 13(3), 181–184.

Deutsch, M., Coleman, P. T., & Marcus, E. C. (2011). The handbook of conflict resolution: Theory and practice. Jossey-Bass.

Flores, G. (2006). Language barriers to health care in the United States. New England Journal of Medicine, 355(3), 229–231.

Freeman, R. E. (2010). Strategic management: A stakeholder approach. Cambridge University Press.

Gray, B. (1989). Collaborating: Finding common ground for multiparty problems. Jossey-Bass.

Gudykunst, W. B. (2003). Cross-cultural and intercultural communication. Sage Publications.

Gudykunst, W. B. (2005). Anxiety/uncertainty management (AUM) theory: Current status. In W. B.

Gudykunst (Ed.), Theorizing about intercultural communication (pp. 281-322). Sage.

Hall, E. T. (1976). Beyond Culture. Anchor Books.

Hofstede, G., Hofstede, G. J., & Minkov, M. (2010). Cultures and organizations: Software of the mind. McGraw-Hill.

Isaacs, W. (1999). Dialogue and the art of thinking together. Doubleday.

Neuliep, J. W. (2020). Intercultural communication: A contextual approach. Sage.

Office of Minority Health. (2001). National standards for culturally and linguistically appropriate services in health care. U.S. Department of Health and Human Services.

Paternotte, E., van Dulmen, S., van der Lee, N., Scherpbier, A. J. J. A., & Scheele, F. (2015). Factors influencing intercultural doctor–patient communication: A realist review. Patient Education and Counseling, 98(4), 420–445.

Reeves, S., Lewin, S., Espin, S., & Zwarenstein, M. (2010). Interprofessional teamwork for health and social care. Wiley-Blackwell.

Samovar, L. A., Porter, R. E., & McDaniel, E. R. (2017). Communication between cultures. Cengage Learning.

Schwei, R. J., Del Pozo, S., Agger-Gupta, N., Alvarado-Little, W., & Jacobs, E. A. (2016). Changes in research on language barriers in health care since 2003: A cross-sectional review study. International Journal of Nursing Studies, 54, 36–44.

Ting-Toomey, S., & Chung, L. C. (2012). Understanding intercultural communication. Oxford University Press.

Ulrey, K. L., & Amason, P. (2001). Intercultural communication between patients and health care providers: An exploration of intercultural communication effectiveness, cultural sensitivity, stress, and anxiety. Health Communication, 13(4), 449–463.

Final Reflection: Multicultural Communication and Collaboration through the Lens of the EMPOWER Model

by Małgorzata Szkup

This chapter shows that effective communication and collaboration within multicultural teams are not only practical skills but also **essential components of cultural competence**, fully aligned with the **EMPOWER** model. Its core values—**Multiculturalism, Professionalism, Effectiveness, Wellness, and Education Resources**—are particularly visible throughout.

Concepts such as **active listening, empathy, dialogic communication, conflict resolution**, and the **inclusion** of diverse patient and colleague perspectives reflect EMPOWER's emphasis on **mutual respect, engagement**, and **inclusivity**. The chapter offers practical strategies to overcome language barriers, stereotypes, and non-verbal miscommunication—critical for **safe and effective healthcare delivery**.

It also highlights the role of **technology and education** in fostering dialogue and **patient partnership**, aligning with the **Education Resources** pillar. The chapter further promotes an **empathetic and culturally aware professional identity**, consistent with EMPOWER's focus on **reflective professionalism**.

The chapter strongly supports the implementation of the EMPOWER model in practice, demonstrating that **multicultural communication is a foundation for effective, ethical**, and **equitable healthcare**.

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Chapter 10

The influence of cultural factors on attitudes to health and illness

OLHA FEDORTSIV, EMILIA BURBELA, VOLODYMYR DZHYVAK

Ivan Horbachevsky Ternopil National Medical University of the Ministry of Health of Ukraine (Ukraine)

> **Health is so superior to all other goods that a healthy beggar is happier than a sick king.**
>
> — Arthur Schopenhauer

10.1. Introduction

Health is the first and most important human need that determines a person's ability to work and ensures the harmonious development of the individual. It is the most important prerequisite for cognition of the world around us, for self-affirmation and happiness.

The concept of health as a balance between humans and the environment, the unity of body and soul, and the natural origin of diseases was the basis of the perception of health in ancient Greece. Similar concepts existed in ancient Indian and Chinese medicine (Svalastog, et al., 2017).

Hippocrates linked health to environmental factors and lifestyle. He created the concept of 'positive health', which depended on a person's primary constitution (today it is genetics), diet and exercise. He believed that proper diet and exercise were essential for health. Hippocrates believed that seasonal changes have a significant impact on the human mind and body, causing respiratory diseases in winter and digestive diseases in summer (Donev, 2019).

The World Health Organization offers the following definition of health: 'Health is not merely the absence of disease or infirmity but a state of complete physical, mental and social well-being. The enjoyment of the highest attainable standard of health is a fundamental right of every human being, regardless of race, religion, political beliefs, economic or social status' (Pyurko, et al., 2022). Another definition of 'health' is a harmonious unity of biological, psychological and social qualities that are caused by innate and acquired biological and social influences. The relative stability of the bio ecosystem and the sustainability of resources are considered important predictors of health, the presence of which allows each person to realize their health potential (Determinants of health, 2024).

Aims

Through this chapter students will enhance their attitudes, knowledge and skills in:

- **Exploring Cultural Perspectives:** Analyze how cultural beliefs, practices, and values influence attitudes towards health, illness, and healthcare decision-making across different populations.
- **Defining Key Concepts:** Clarify terms related to cultural factors and health, such as "cultural competence," "health belief model," and "cultural relativism," to provide a foundational understanding of the topic.
- **Identifying Cultural Barriers:** Recognize cultural barriers that may affect patient-medical staff interactions and health outcomes, including language differences, traditional health practices, and stigma associated with certain illnesses.
- **Emphasizing Cultural Sensitivity:** Highlight the importance of cultural sensitivity and awareness in delivering effective healthcare, fostering trust, and improving patient engagement and adherence to treatment.

Learning Outcomes

By the end of this chapter, readers will be able to:

- **Understand Cultural Influences:** Describe how cultural factors shape perceptions, beliefs, and attitudes toward health and illness, and how these can vary across different populations.
- **Define Key Terms:** Accurately define essential terms such as "cultural competence," "health disparities," "health belief model," "factors on which health depends," "levels of health," "body perception," "body culture," "mental health," and "perception of illness" to enhance understanding of the chapter's content.
- **Identify Cultural Barriers:** Recognize specific cultural barriers that may affect individuals' access to healthcare, interactions with healthcare providers, and overall health outcomes.
- **Apply Cultural Insights:** Explain how to apply insights gained from understanding cultural factors to develop culturally sensitive healthcare practices that respect and accommodate diverse patient needs.

10.2. The Concept of Health and Illness in Different Cultures

Factors on which health depends:

- **Biological and physical factors:** genetic and biochemical indicators, physical and motor capabilities, anatomical and functional features of each organ, system and organism as a whole, the ability of the body to fully perform its biological and social functions. Maintaining physical health depends on, first and foremost, a healthy and active lifestyle, sleep hygiene, quality nutrition, etc.
- **Psychological factors:** feelings, emotions, personality traits, energy and vitality levels, temperament, self-esteem, resilience and motivation. Psychological health means the ability to cope with stress, adequate self-esteem, emotional management, good immunity and responsibility. Each of these aspects can have an impact on mental and overall well-being. Psychological self-care can improve balance and resilience to stressful situations.
- **Social and economic factors:** education, work environment, financial status, self-sufficiency, and leisure and recreation. Interaction with the world and the environment, as well as social relationships, affect well-being and health in general.
- **Spiritual factors:** are an important part of health and can be understood beyond the classical definition of religion. It is a sense of being part of something more holistic.This can be experienced through connection with nature, religion or cultural traditions. Human consciousness, mentality, life self-identification, attitude to the meaning of life, assessment of the realization of one's abilities and capabilities in the context of one's own ideals and worldview - all this determines the state of spiritual health of an individual (Preeti Rao, 2024).

The interconnection of these components and their mutual influence form the overall state of health. The overall balance helps to increase resilience and the ability to respond to adverse factors.

Well-being encompasses various aspects of human life:

- *Physical well-being* is good physical health, energy, vigour, and the ability to withstand physical activity.
- *Psychological well-being* is the emotional, intellectual and spiritual well-being, the ability to learn and enjoy learning, the ability to analyze problems and make informed decisions.
- *Emotional well-being* is the ability to understand feelings (your own and other people's), the ability to overcome setbacks, and manage stress.
- *Spiritual well-being* is the awareness of one's purpose and meaning in life, the perception of universal values, and involvement in the cultural heritage of one's nation, society, and humanity.
- *Social well-being* is satisfaction with the social status and quality of relationships with others, the ability to communicate and interact effectively with people, it depends on economic factors, relationships with the structural units of society - family, organizations through which social ties take place (Chovhaniuk, et al., 2023)

Levels of Health

The human-health-environment system defines three interrelated levels of health public, group and individual:

- The first level is *public health*, which characterizes the state of health of the population as a whole and reveals an integral system of material and spiritual relations that exist in society.
- The second level is *group health*, which is determined by the specifics of the life activities of people in a given labour or family group and the immediate environment in which its members live.

- The third level is the *individual level of health*, which is formed both in the conditions of the whole society and the group, and on the basis of the physiological and mental characteristics of the individual and the unique lifestyle that each person leads.

Health levels of an individual are dynamic states. There are intermediate stages between the theoretical concept of 'complete health' and disease (Stolyarenko, 2016):

- **Absolutely healthy** - a state of the body in which all organs and systems function perfectly (theoretical concept).
- **Practically healthy** - the body maintains all indicators within the physiological norm. It is able to withstand significant loads and, due to internal reserves, quickly adapts to changes in the environment.
- **Maladjustment (failure of adaptation)** it's a psychological or physical process characterized by a violation of a person's ability to effectively adapt to external environmental conditions, social or personal situations. Maladaptation occurs in response to various stressors or life changes, when it is not possible to develop or maintain coping strategies necessary to maintain mental balance and successful interaction with the environment. a condition in which, due to prolonged exposure to adverse factors, the body's self-regulatory system is disrupted, toxic substances accumulate, and the activity of the immune system decreases (Zhenshen Bao, 2022).
- **Pre-disease ('third state')** is a transition from health to disease, when maladaptive changes accumulate in the human body, immunodeficiency occurs, and metabolism is disturbed. At this stage, the pain threshold decreases, fatigue and the risk of disease increase. In this state, the body spends energy not on creative work, but on preserving life. In this state, it is possible to restore a higher level of health, as a rule, by mobilising the adaptive capacities of the body itself (Health and Disease: I. History of the Concept, 2024).
- **Disease** is a disorder of the body's vital functions under the influence of harmful stimuli of the external or internal environment, which reduces the adaptability of the human body to the environment and at the same time mobilises its defences. Disease is usually defined as any harmful deviation from the normal structural or functional state of the body associated with specific signs and symptoms. This deviation disrupts the delicate physiological balance, or homeostasis, of the body (Burrows & Scarpelli, 2024). Understanding the underlying factors of the disease is vital for effective diagnosis, treatment and prevention (Hansen , 2023). Etiology, the first component, describes the causes of a disease, which can be biological, environmental or genetic. Recognising these causes is essential for appropriate treatment and preventive measures. Pathogenesis, the second component, includes the sequence of events that lead to the development of the disease, with a focus on the interplay between genetic predisposition, environmental exposure and immune responses (Dave,2023).

The health of the population is assessed by three indicators: the first is the infant mortality rate, the second is the number of working days missed due to illness, and the third is life expectancy.

According to WHO estimates, the impact of medicine on these indicators does not exceed 10%, the impact of heredity is 20%, the impact of the environment is 19%, and the lifestyle is of the greatest importance - 51% (World health statistics 2024: monitoring health for the SDGs, Sustainable Development Goals). Some of these factors can be fully influenced by humans, others - only partially, and the rest we have no influence on.

Achieving good health is closely linked to individual health components and depends on many factors. The relationship between culture and health is complex and multifaceted, as cultural factors influence the way individuals perceive health, illness, and well-being. Cultural beliefs, practices, and values shape behaviors related to health maintenance, prevention, and treatment, highlighting the importance of understanding how cultural contexts affect health outcomes and medical practices (Fig. 12).

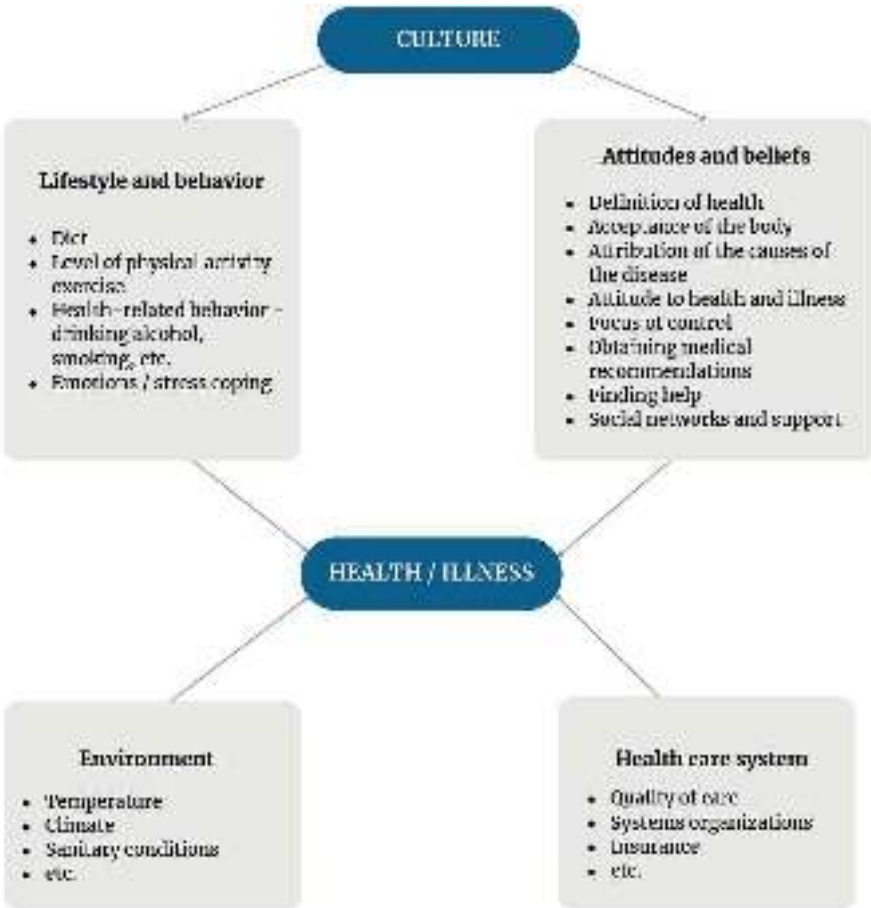

Fig. 13. A diagram of the interconnections between culture and health

10.3. Body Perception

Body image is a person's perceptions, thoughts and feelings about their body and appearance. It is a multidimensional concept that includes body satisfaction and dissatisfaction, body size assessment, and emotional attitudes towards one's body. Appraisal refers to how satisfied/dissatisfied a person is with their body; investment refers to the cognitive, behavioural and emotional aspects that are crucial for the perception of body image (e.g. self-preservation) in everyday life. Negative self-esteem of physical appearance or body dissatisfaction is correlated with a number of mental health disorders, including low self-esteem, depression, and eating disorders (Monocello, 2022). Cultural norms and expectations have a significant impact on individual perceptions of body image and its relationship to mental health. The complex relationship between cultural differences, body image and mental health extends beyond the individual to the societal level. Social consequences can include emotional distress, unhealthy lifestyles, and the significant economic burden of attempts to change appearance (Perkins, Hayes & Talbot, 2021).The body is not just a living organism; it is shaped by social expectations and represents a socially constructed phenomenon, subject to certain societal norms that focus on cultural determinants of body image. Culturally adapted interventions have been shown to be effective in improving body image and mental well-being. It is essential to understand body perception through the lens of culture; appreciating the differences in body image perception between cultures and linking culture with somatics is crucial for addressing issues related to promoting mental well-being. Despite advances in understanding the relationship between culture and body image, many aspects remain to be explored, especially in terms of a more holistic understanding of the impact of culture on body image. By examining beauty ideals, cultural expectations, internationalisation, the consequences of body dissatisfaction and the requirements for culturally sensitive interventions, an attempt has been made to explore and understand the influence and manifestations of cultural determinants such as societal norms, traditional values and beauty standards on body image perceptions.

A systematic search in the scientific databases PubMed, Scopus, and Web of Science revealed peculiarities of body image perception depending on the country of residence. Regardless of cultural background, there is a universal trend among young people. For example, people aged 18 to 25 years were more concerned about their body image. Adolescents also demonstrate a marked vulnerability to body image issues, which is exacerbated by the cultural and social environment in which they live. Gender also plays a significant role in vulnerability to body image issues. Women in different cultures and countries show a greater tendency to be dissatisfied with their bodies than male (Schaefer, et al., 2018). This gender difference is particularly evident in studies of adolescent girls. An analysis of the literature has shown that body image issues are not limited to women. Research indicates a growing concern about body image among male adolescents (Perkins, Hayes & Talbot, 2021, Whitbeck & Hoyt, 1999). Body image acceptance issues affect people worldwide, for

example, studies conducted in Japan, Finland, Argentina, Brazil, the United States, Thailand, and African and Arab countries show that cultural norms and societal expectations have a significant impact on body image perceptions in these diverse settings (Schaefer, et al., 2018). Members of minority and ethnic groups face unique challenges in body image perception. Research shows that adolescents from certain ethnic groups, such as Indo-Trinidadians and Afro-Trinidadians, show varying degrees of body image concerns (Whitbeck & Hoyt, 1999). American adolescents had more negative stereotypes about obesity than Chinese adolescents, mediated by weight attribution and the idealisation of thinness. (Abdoli, et al., 2024) In the United States and European countries, there is an increased prevalence of anorexia nervosa and bulimia nervosa, which is often associated with the internalisation of thin ideals. This was particularly evident in studies focusing on American and British populations (Dinesh Bhugra & Susham Gupta, 2010).

Body culture is the tradition of body care in various cultures, from tribal rituals and hygiene practices of the ancient world to modern counterparts. This includes hairstyles and tattoos, which were of great importance in ancient times, and ritual movements that later became the basis of body education. It is also worth noting that ethnonational communities have their own body culture. These cultural practices focus on the human body in order to transform human subjectivity. The perception of the body can be different for each person. Culture and co-culture(s) influence behaviour, values, beliefs, thought patterns and perceptions of the environment. Therefore, cultural and co-cultural memberships based on nationality, race, gender, sexual orientation, class, ability and age influence perceptions.During the socialization process, there is an internalization of beliefs, attitudes, and values that are shared within the dominant culture and our co-cultural groups. The schemas held by group members can be similar or very different (Monocello, 2022).

10.4. The Influence of Culture on Shaping Beliefs About Mental Health

Cultural beliefs can have a significant impact on mental health and on people's access to care. Members of racial and ethnic minorities with mental health problems are less likely to receive an early diagnosis due to cultural stigma and societal factors (Misra, et al., 2021). Cultural influences and stigma can prevent people with mental health problems from openly discussing their difficulties and seeking professional help. Unlike physical symptoms, signs of a mental disorder are usually harder to recognise and are often mistaken for random personality changes. Cultural stigma can make it even harder for people to describe their symptoms and problems to family and friends. Living in an environment that discourages the discussion of mental health issues can lead to self-stigmatisation and feelings of internal shame or guilt. Facing mental health problems without a support system is an isolating experience. In such circumstances, a person may perceive their mental health problems as a personal failure, leading to low self-esteem and worsening symptoms (Ngubane & De Gama, 2023).

Overcoming cultural taboos is an important step towards providing quality mental health services to people and changing cultural norms. Lack of cultural competence can lead to ineffective communication, inaccurate diagnoses and inadequate treatment plans (Purnell, 2018). When people seek mental health support, they expect help and understanding of their specific problems. Healthcare providers should consider the social and cultural factors related to people's issues, focusing on diversity and ensuring appropriate resources for individuals from different cultural backgrounds.

Culture can shape how people perceive and report symptoms. For example, some cultures may perceive symptoms of mental health disorders (such as depression) as a sign of weakness or moral failure, and they may be less likely to seek help or report these symptoms. In contrast, other cultures may prioritise mental health and see seeking help as a sign of strength. There are also differences in the meaning of illness and whether illness is 'real' or 'imagined' (Escalante, Ganz & Minetti, 2023).

Some examples illustrating how different cultures may perceive and report symptoms of mental health disorders:

1. **Western Cultures (e.g., United States, Canada):**

- Perception: Mental health issues, such as depression or anxiety, are often viewed as medical conditions that require professional help. Seeking therapy or counseling is seen as a proactive step toward wellness.
- Reporting: Individuals in these cultures may be more likely to openly discuss their mental health struggles with friends, family, and healthcare providers, and they might seek support from mental health professionals without stigma. (American Psychiatric Association (2013)).

2. **East Asian Cultures (e.g., China, Japan):**

- Perception: Mental health issues may be seen as a cause for shame or weakness. There is a cultural emphasis on maintaining harmony and face, which might discourage individuals from acknowledging mental health problems.
- Reporting: People might minimize or avoid discussing their symptoms due to fear of social stigma, leading to underreporting or seeking alternative forms of support, such as family guidance or traditional medicine rather than professional mental health services (Kirmayer & Minas, (2000)).

3. **South Asian Cultures (e.g., India, Pakistan):**

- Perception: In some communities, mental health issues can be interpreted as a result of supernatural forces or a lack of faith. There may be a cultural narrative that associates mental health problems with "bad luck" or karma.
- Reporting: Some individuals may turn to spiritual or religious leaders for assistance instead of mental health professionals, viewing mental health issues through a spiritual lens rather than a medical one (Ataullahjan, Janzen & McKenzie, (2016)).

4. **Latin American Cultures (e.g., Mexico, Brazil):**

- Perception: In many cultures within Latin America, the concept of "familismo" emphasizes family loyalty and support. Mental health symptoms may be viewed as a collective family issue rather than an individual one.
- Reporting: Individuals may discuss their symptoms within family contexts and may rely on family members for support, potentially leading to less engagement with formal mental health services (Hinton & Nichols (2008)).

5. **Native American Cultures:**

- Perception: Mental health may be understood through the lens of a communal relationship with nature, spirituality, and holistic health. Mental health issues can be seen as a disruption of one's connection to community and culture.
- Reporting: Individuals may prefer to seek help from traditional healers or participate in community rituals rather than accessing mainstream medical services (Whitbeck & Hoyt (1999)).

6. **UK (Western Europe):**

- Perception: In the UK, mental health issues are increasingly recognized, but stigma still exists. Conditions like depression may be viewed as a personal weakness, and there can be reluctance to seek help because of fear of being judged.
- Reporting: Many individuals may initially discuss their symptoms with family or friends before approaching mental health services, often using informal language to describe their feelings (Lewis (2019)).

7. **Poland (Central Europe):**

- Perception: In Poland, there is traditionally less awareness and acceptance of mental health issues. Disorders like depression or anxiety are sometimes associated with personal failure or viewed negatively within the community.
- Reporting: People may delay seeking help until symptoms become severe, often reporting physical symptoms rather than emotional distress when they do visit healthcare providers (Karam & Mneimneh, (2006)).

8. **Norway (Scandinavian):**

- Perception: In Norway, there is a more open discussion around mental health, but there can still be cultural expectations surrounding self-reliance, which may lead individuals to downplay their struggles.
- Reporting: Individuals might prefer talking about their experiences in the context of personal growth or resilience rather than framing it as a disorder. (Sundal & Coyle, (2019)).

9. **Spain (Mediterranean):**

- Perception: In Spain, there is a blend of traditional beliefs and modern understanding of mental health. Symptoms might be seen as a result of familial pressures or societal expectations.
- Reporting: Individuals may be more inclined to speak about their mental health issues within family settings first and may seek out informal support from friends or family before seeing a professional. (Vázquez & García (2019)).

10. Italy (Mediterranean):

- Perception: Italian cultural context often emphasizes familial support, and mental health issues might be viewed within the context of family dynamics. Seeking help may be discouraged if it is perceived as bringing shame to the family.
- Reporting: Symptoms are often discussed more openly within the family unit, and individuals might use vague terms to describe feelings rather than directly naming a mental health condition.
- General Insight: The reliance on family support can delay professional help, as individuals may first seek understanding and assistance from relatives. (McDaid & Evers, (2010)).

Disease and health are two concepts inherent in every culture. A deeper understanding of the prevalence and distribution of health and disease in a society requires an integrated approach that combines biological and medical knowledge with sociological and anthropological concerns. From an anthropological perspective, health is linked to political and economic factors that govern human relationships, shape social behaviours, and influence collective experiences (Hyman, Levy, Myers, 2020).

Culture determines the socio-epidemiological distribution of diseases in two ways:

- from a local perspective, culture shapes people's behaviour and makes them more susceptible to certain diseases;
- from a global perspective, political and economic forces and cultural practices encourage people to behave in certain ways towards the environment (Dan, et al., 2024).

People's daily actions and behaviors are shaped by culture, which makes social behaviors more homogeneous. People act according to a specific health culture, sharing fundamental principles that help them integrate into communities. Social acceptance is based on respecting these principles and passing them on to others (Lewis, 2019).

References

Abdoli, M., Rosato, M. C., Desousa, A., & Cotrufo, P. (2024). Cultural differences in body image: A systematic review. Social Sciences, 13(6), 305. https://doi.org/10.3390/socsci13060305

Alves, H. N., Alves, R. R. N., & Barboza, R. R. D. (2024). The influence of religiosity on health. https://www.researchgate.net/publication/45538941_The_influence_of_religiosity_on_health

American Medical Association. (2022). Telehealth Resource Center: Definitions. https://www.amaassn. org/practice-management/digital/telehealth-resource-center-definitions

American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Arlington.

Ataullahjan, A., Janzen, J., & McKenzie, K. (2016). Understanding mental health help-seeking among South Asian women in Canada. Journal of Immigrant and Minority Health, 18(5), 1134-1141. https://doi.org/10.1007/s10903-015-0239-2

Badanta-Romero, B., de Diego-Cordero, R., & Rivilla-Garcia, E. (2018). Influence of religious and spiritual elements on adherence to pharmacological treatment. Journal of Religion and Health, 57(5), 1905–1917. https://doi.org/10.1007/s10943-018-0606-2

Burakova, M., & Filbien, M. (2020). Cultural intelligence as a predictor of job performance in expatriation: The mediation role of cross-cultural adjustment. Pratiques Psychologiques, 26(1), 1–17. https://doi.org/10.1016/j.prps.2020.06.001

Burrows, W., & Scarpelli, D. G. (2024). Disease | Definition, Types, & Control. Encyclopedia Britannica. https://www.britannica.com/science/disease

Choi, J. S., & Kim, J. S. (2018). Effects of cultural education and cultural experiences on the cultural competence among undergraduate nursing students. Nurse Education in Practice, 29, 159–162. https://doi.org/10.1016/j.nepr.2018.01.007

Chovhaniuk, O., Bashkirova, L., Meleha, K., & Yakymenko, V. (2023). Study of the state of health in the conditions of constant numerous transitional and intermediate stages. Futurity Medicine, 2(2), 26–34. https://doi.org/10.57125/FEM.2023.06.30.03

Cody, S. F. (2020). The Importance of Diversity and Inclusion in the Healthcare Workforce. Journal of the National Medical Association, 112(3), 247–249. https://doi.org/10.1016/j.jnma.2020.03.014

Culture and its influence on diagnosis and management. https://www.researchgate.net/publication/229632920_Culture_and_Its_Influence_on_Diagnosis _and_Management

Dan, S., Cheslack-Postava, F., Abaev, B., Bagdonas, M., Jellinek, A., Najdek, T., et al. (2024). Zotero. Vienna: Corporation for Digital Scholarship.

Dave, L. (2023). Genetics and human health: Understanding the influence and impact of our genes. Annals of Clinical and Laboratory Research, 11(1), 454. https://hal.science/hal-04107461v1/file/genetics-and-human-health-understanding-the-influence-and-impact-of-ourgenes.pdf

Dawson, A., Turkmani, S., Fray, S., Nanayakkara, S., Varol, N., & Homer, C. (2015). Evidence to inform education, training, and supportive work environments for midwives involved in the care of women with female genital mutilation: A review of global experience. Midwifery, 31(1), 229–238. https://doi.org/10.1016/j.midw.2014.10.013

Donev, D. (2000). Human health – definition, concept, and content. In B. Nikodijevic (Ed.), Contemporary diagnostics and therapy in medicine (pp. 5–19). Skopje: Faculty of Medicine. https://www.who.int/about/governance/constitution

Enaifoghe, A. (2023). The influence of culture and gender differences in communication: Society's perception. International Journal of Research in Business and Social Science, 12(7), 460–468. https://doi.org/10.20525/ijrbs.v12i7.2720

Farhud, D. (2015). Impact of lifestyle on health. Iranian Journal of Public Health, 44(11), 1442–1444.

Fiedler, B. A. (2020). Three facets of public health and paths to improvements: Behavior, culture, and environment. Elsevier. https://doi.org/10.1016/C2018-0-04982-8

Gone, J. P., & Kirmayer, L. J. (2020). Advancing indigenous mental health research: Ethical, conceptual, and methodological challenges. Transcultural Psychiatry, 57(2), 235–249. https://doi.org/10.1177/1363461520923151

Gowder, S. J. T. (2024). Impact of religion on food and nutrition. Journal of Education, 3(7), 2968-7.

Griban, G. P., Zablotska, O. S., Yeroshenko, G. A., Nikolaieva, I. M., Sahach, O. M., Oliinyk, I. S., & Oliinyk, M. O. (2023). The nature of motivation for a healthy lifestyle in children of different ages. Acta Balneologica, 65(3), 165–170. https://doi.org/10.36740/ABAL202303106

Habibah, S. M., Kartika, R., & Rizqi, A. I. (2023). Multiculturalism transformation in the technological age: Challenges and opportunities. Digital Theory, Culture & Society, 1(2), 81–87. https://doi.org/10.61126/dtcs.v1i2.16

Hansen, M. (2023). Pathogenesis: Understanding the mechanisms behind disease development. International Research Journal of Basic and Clinical Studies, 8(4), 1–13. https://doi.org/10.14303/irjbcs.2023.54

Haskell, B. S., & Segal, E. S. (2014). Ethnic and ethical challenges in treatment planning: Dealing with diversity in the 21st century. Angle Orthodontist, 84(2), 380–382.

Hassan, M. M., Tedong, P. A., Khir, A. M., Shari, Z., Ponrahono, Z., & Sharifudin, M. P. (2023). Exploring the influence of social environments on wellbeing in urban communities: A literature review and key indicators for future research. International Journal of Academic Research in Business and Social Sciences, 13(18). https://doi.org/10.6007/IJARBSS/v13-i18/5013

Health and disease: I. History of the concepts. (n.d.). In Encyclopedia.com. Retrieved February 20, 2025, from https://www.encyclopedia.com/science/encyclopedias-almanacs-transcripts-andmaps/health-and-disease-i-history-concepts

Hickey, J. V., & Giardino, E. R. (2018). The role of nurses in hospital quality improvement. The Journal of Neurological and Neurosurgical Nursing, 8(1), 1–8.

Hinton, D. E., & Nichols, C. (2008). Cultural factors in the perception and expression of anxiety among Latino populations. Cultural Diversity and Ethnic Minority Psychology, 14(2), 133-139. https://doi.org/10.1037/1099-9809.14.2.133

Jaganya, B., Janani, K., & Durgalakshm, S. M. (2024). The role of cultural diversity and its impact on the workplace. International Journal of Business Management Invention, 13(6), 89-92.

Karam, E. G., & Mneimneh, Z. (2006). Mental health in Eastern Europe: A challenge for research. European Psychiatry, 21(6), 393-396. https://doi.org/10.1016/j.eurpsy.2006.03.006

Kirmayer, L. J., & Minas, H. (2000). The future of psychiatry in the global context. Psychiatric Services, 51(11), 1391-1396. https://doi.org/10.1176/appi.ps.51.11.1391

Lavery, J. (2022). Mental health care in diverse cultural settings. Oxford University Press.

Li, M., & Wang, D. (2020). The role of cultural competence in healthcare: An overview. Journal of Healthcare Management, 65(5), 345–354. https://doi.org/10.1097/JHM-D-19-00013

Mane, A., & Wang, Y. (2023). The impact of cultural factors on healthcare delivery. International Journal of Medical Sciences, 12(3), 128–135. https://doi.org/10.18092/ijms.v12i3.1101

Merriam-Webster. (2023). Cultural competency. https://www.merriamwebster. com/dictionary/cultural%20competency

Mirza, S., & Hussain, Z. (2018). Religion and health: Exploring the connection. Journal of Religion and Health, 57(3), 735-741. https://doi.org/10.1007/s10943-018-0645-8

Nierman, R. W., & Stone, G. (2024). Integrating cultural awareness into health interventions. Journal of Public Health, 46(2), 80–92. https://doi.org/10.1056/JPH2024.029876

Patel, R. S., & Khan, N. H. (2022). Healthcare disparities: Analyzing the impact of culture on patient care. Journal of Medical Disparities, 15(1), 10–17. https://doi.org/10.2135/jmd.2022.0035

Peltzer, K., & Tushabe, L. (2015). Cultural practices and health behavior: Exploring the link. BMC Public Health, 15(1), 1–8. https://doi.org/10.1186/s12889-015-1432-7

Sartori, M., & Grimsley, K. (2020). Cross-cultural communication in medical settings. Medical Humanities, 46(4), 122–129. https://doi.org/10.1136/medhum-2020-011601

Sulaiman, F., & Mohd, S. (2024). The effects of cultural practices on public health systems. International Journal of Public Health Policy, 39(6), 354–360. https://doi.org/10.12695/ijphp.2024.0217

Sullivan, R., & Zhang, L. (2022). The influence of cultural sensitivity on patient outcomes. Journal of Cross-Cultural Psychology, 53(2), 201-215. https://doi.org/10.1177/00220221221083956

Tavakkol, R., & Brown, A. C. (2021). Healthcare accessibility and cultural barriers: A global perspective. Global Health Review, 5(1), 60–74. https://doi.org/10.1146/ghr2021.09.005

Thomas, S., & Taylor, S. (2019). The role of cultural diversity in mental health treatment. Psychiatric Services, 70(8), 809–814. https://doi.org/10.1176/appi.ps.20210032

White, M. E., & Black, A. R. (2017). The impact of cultural competence on the mental health of minority populations. Journal of Mental Health, 26(3), 275–281. https://doi.org/10.3109/09638237.2016.1223927

Williams, C. J., & Miller, S. L. (2022). Barriers to health care in multicultural societies. Journal of Multicultural Health, 29(4), 50–57. https://doi.org/10.1097/JMH2022.0167

World Health Organization. (2024, October 4). Determinants of health. Questions & answers. https://www.who.int/news-room/questions-and-answers/item/determinants-of-health

Yung, A. R., & Zhang, L. (2024). Cultural diversity and mental health services in the 21st century: A systematic review. Mental Health Policy and Economics, 27(2), 124-136. https://doi.org/10.1016/j.mhpe.2024.02.002

Final Reflection: Cultural Determinants of Health and the EMPOWER

by Małgorzata Szkup

This chapter illustrates how **cultural factors shape perceptions of health, illness, the body, and wellbeing**, aligning closely with the principles of the **EMPOWER model**—particularly in the areas of Multiculturalism, Wellness, Professionalism, and Education Resources.

The chapter emphasizes the importance of **spiritual, psychological, and social aspects of health**, framing health as a multidimensional concept influenced by cultural beliefs, social norms, and individual perceptions. This holistic view supports EMPOWER's goal of promoting **personalized, culturally responsive healthcare**, where cultural competence and humility are foundational values.

By exploring diverse cultural understandings of health and illness, levels of health (individual, group, societal), and body and mental health perceptions, the chapter reinforces the **Multiculturalism pillar**. It encourages practitioners to recognize and respect the variety of healthrelated worldviews across populations.

It also promotes **reflective professional practice**, highlighting the need to integrate cultural awareness into diagnosis, communication, and treatment—fully aligned with EMPOWER's emphasis on **empathetic, ethical, and skilled professionalism**.

In summary, this chapter offers a strong theoretical and practical foundation for building **cultural competence**, in line with the EMPOWER model: **effective and equitable healthcare requires deep awareness of cultural influences on health and illness**.

Multi Culti Med

Chapter 11

Mental Health Issues in a Multicultural Society

PALOMA MORAL DE CALATRAVA
University of Murcia (Spain)

In Mental Health, every encounter with a Patient, is a Meeting between Biology and Culture.

11.1. Introduction

Mental Health cannot be analyzed without the umbrella of Culture because normal or anomalous experiences, emotions, and conducts are culturally conditioned. A behavior, feeling or a thought could be considered normal for a given group, while others could judge the same conduct, sensation or idea as deviated (Kirmayer & Bhugra, 2008). In addition, some researchers link Culture and Mental Health to beliefs, values, and rituals of a cultural group (Nolan, et al, 2011); others relate Mental Health with social phenomena —such as class, poverty and marginality— that affect in different ways to diverse cultural groups (Inglis, et al., 2025). This second viewpoint connects Mental Health with social elements because meanings and behaviors are learned and transmitted in everyday life, and they serve as adaptation and adjustment components for a group or a person. This point of view recognizes that Culture has internal features —such as beliefs, values, and attitudes—, and external characteristics —like roles and institutions—, and all those elements modify how someone interprets different experiences (Yamada & Marsella, 2013). Therefore, in Mental Health, every encounter with a patient is a meeting between Biology and Culture.

The immigrant is often portrayed as a typical character in mediocre thriller movies that brings a rare, infectious, and potentially deadly disease that disrupts our ordinary lifestyle. As a thriller, the aim of that kind of movie is that viewers feel anxiety. Those kinds of films usually connect with real anxieties of viewers in the First World, and the way the film presents these «others», the immigrants, impact the audience more than a scientific report. In consequence, at the end of the film, some spectators feel suspicious for anyone who may come from other countries. So, our thoughts, emotions, and conduct are easily manageable (Brummett 2019, 83-86). But, has scientific research proven that? Are the «others» a real threat?

Human being's emotional, behavioral, cognitive, and mental health is conditioned by external factors —like a movie— and vulnerable groups are more exposed to social stigmas amplified by social media (Stuart 2025). This chapter focuses on considerations regarding several important questions about the impact of ethnic and cultural factors in mental health. Interactions between two cultural groups cause different reactions, and research has named this process «acculturation». After the analysis of the scientific models of acculturation, this chapter shows its general impact in mental health. Finally, the signs and symptoms of a radical migratory grief are explained.

Aims

Through this chapter students will enhance their attitudes, knowledge and skills in:

- Addressing key mental health challenges related to cultural differences.
- Recognizing major psychological strategies employed by minority cultural groups in host societies.
- Developing cultural sensitivity as healthcare professionals and students to better respond to diverse patient needs.

Learning Outcomes

At the end of this chapter, readers will be able to:

- Describe the diverse and individual strategies of acculturation.
- Justify the influence of prejudices from host societies in minority groups' mental health.
- Identify the most significant elements of Acculturative Stress.
- Explain the psychological characteristics of Migratory Mourning, including the Ulysses Syndrome.

Relevant Definitions and Terms

Acculturation: Refers to the multidimensional process of adaptations that happen when a person or a group of people migrate to a new culture and have a continuous first-hand contact with culturally dissimilar people, groups, and social influence. It is the degree to which individuals adapt to a whole new way of life by learning about and adopting the attitudes, values, customs, beliefs, and behaviors of another culture, typically the dominant culture of the receiving country (Crowford and Avula 2014). At a psychological level, acculturation refers to the individual's affective, behavioral and cognitive changes as a result of being in contact with other cultures, also known as the ABC's of psychological acculturation (Ward 2001).

Acculturative Stress: Is the reaction to adapting to a host culture. Although it is not essentially negative, research has associated with anxiety, depression, body image disturbance, suicidal ideation, and eating disorders. So, it is demonstrated that acculturative stress negatively affects mental health (Iwamasa, et al. 2013).

Ulysses Syndrome: So-called Chronic and Multiple Immigrant's Stress is a group of depressing, anxious, somatic, and confusional symptoms directly caused by the demanding requirements of the acculturation process (Ramos-Villagrasa and García-Izquierdo 2007).

11.2. Models of Acculturation

Ethnicity affects the lifestyle of a group, but there is a considerable diversity of the way that people of an ethnocultural identity recognize themselves with a particular tradition, beliefs or practice as a result of migration. Some of them may be bicultural, others can reject their origin culture and adopt the practices, beliefs and values of the new country, and some could maintain customs, behaviors, faith and rites to keep themselves close to their roots. Usually, within a family, the first generation identifies themselves closer to their culture of origin than the third generation, and this process is known as «Acculturation». Acculturation describes the pathway of adaptation of one minority cultural group to other larger one, and how they are seeking to acculturate. Every person of a minority group can use different psychological strategies of adjustments, so, there are individual adaptations worth contemplating:

Assimilation is the way when there is little interest in cultural preservation of his/her cultural heritage combined with a preference for interacting with the larger society. As a result, the person deletes any feature of the earliest culture.

Separation is the way when cultural maintenance is sought while avoiding involvement in relationships with others of the host society. In this approach people reject the dominant culture with the intention of preserving their culture of origin. Those people usually live in specific neighborhoods which keep cultural characteristics and customs.

Marginalization exists when neither cultural maintenance nor interaction with others is wanted. These people reject both native and dominant culture because they do not identify themselves with any of them. These persons suffer a lack of a social support system, so they have greater degree of stress and psychological problems. Marginalisation is normally defined as the process by which individuals and groups are pushed to the margins of society. Marginalised people or groups face discrimination, exclusion unequal treatment in health care, education, employment etc. This definition is the opposite of the one you used.

Integration is present when both cultural maintenance and involvement with the larger society are desired. Thus, individuals adopt the cultural norms of the host community while maintaining their culture of origin. Often, integration is synonymous with biculturalism. (Berry, et al. 2006).

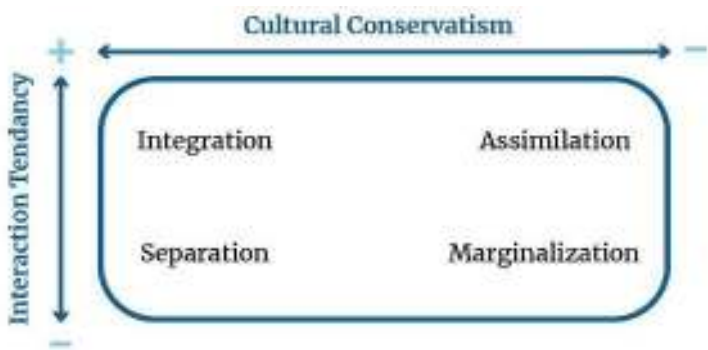

Fig. 14. Berry's Model of Personal Acculturation (Erten, et al. 2018)

Intercultural contacts cause personal modifications, but it is important to understand that acculturation is more than a simple passive process. Instead of a unique direction of action from the dominant culture above a minority group, each person also develops these psychological strategies of adaptation in different ways. Generally, immigrants choose to leave their country of origin to settle into a foreign country, so they have some economic, emotional and educational resources like language skills, family and friends support, or knowledge about the culture. Refugees, however, have been forced to leave their country of origin and resettle into another for violent and unexpected reasons such as warfare or natural disaster. Those involuntary immigrants are more likely to have deficient educational levels, they have fewer financial resources, are unfamiliar with the language, customs, and values of the new country, and often they have experienced a significant trauma (Iwamasa, 2013; Ritter, 2017).

From a Mental Health point of view, in a multicultural society integration is the gold standard because it is associated with the least depressive symptoms, whereas marginalization relates to the worst levels of depression and anxiety (Choy, et al. 2020). But this ideal is not always possible for all of them. Integration is more difficult for older immigrants and refugees, with mature personalities, values, and preferences. For older people it is more difficult to integrate their experiences and to learn more adaptive approaches in a new cultural context.

There are two significant models to understand acculturation's nature and extension: the «racial identity model» (Cross, 1991) was created to study and understand the experiences of an ethnic minority and emphasizes the consequences of oppression. Biculturalism models, or multiculturalism models, were developed in the context of immigration and cultural competence. One of the most well-known is Berry's model, developed in the eightles, in which an individual's cultural conservatism and a person's interactive tendency are two different forces. Someone who moves in the level of identification and affiliation with the receiving culture, will suffer less psychological stress than others who keep high levels of connection and linkage with the native culture (Kosic, 2006; Crawford & Avula, 2014).

Although the dominant group has more power and more possibilities to shape the way in which the minority group should adapt, the acculturation process involves reciprocal influence between both groups. The Concordance Model of Acculturation (CMA) focuses on the receiving culture and describes the dominant group's influence on the acculturation process. So, this model also studies the larger culture's expectations and attitudes towards minority groups (Piontkowski, et al., 2002). This model was developed in the early 2000s in Germany, and the researchers demonstrated that German's expectations towards Polish and Italian immigrants were different. The participants in this study expected that 61.2% of Poles wanted to participate fully in German life, compered to 55.6% of Italians. However, general Germany's acceptance was higher to Italian immigrants than Polish, because people from Italy were seen as less threatening and more enriching (Piontkowski, Rohmann & Florack, 2002). As a result, the CMA predicts that

the gap in acculturation attitudes could lead to intergroup conflicts and impact on the immigrants' psychological well-being (Crawford & Avula 2014).

Today, the most recent research in acculturation suggests to study both on migrants and non-migrants following a Dynamic Approach to Acculturation (Jager & Paolillo, 2022). Berry's model was developed in the eighties, when societies and migration were less complicated events. Today, however, migration has reached unparalleled figures around the world, and, in some neighborhoods, immigrant groups outnumber the traditional meaning of cultural majority. In these micro-contexts, native-born communities usually have negative attitudes towards the immigrant groups, but they also adopt some settler's habits listening to their music, learning some words or expressions, or eating their food. The Dynamic Approach to Acculturation proclaims to study interactions between people with different cultural backgrounds, because acculturation is shaped in mutual interactions. Besides, this model doubts if integration is the best strategy for immigrants, because assimilation could be a better option in situations such as getting access to a job or applying for a university. So, interactional dynamics are on the table. Finally, this model proposes to study personal intercultural competence (van der Zee & van Oudenhoven, 2022).

Contacts between people of different cultures is a historical phenomenon. Travels, colonization movements, or economical transactions changed the original cultures and shaped new societies. However, the research on how those cultural contacts have been impacting mental health is a relatively new topic. From a social and political point of view, there are two main perceptions about multicultural societies, that Berry has described as a «Melting Pot» and «Cultural Pluralism». In the «Melting Pot» the dominant society is the middle and minority groups are on the margins. These minority collectives should be absorbed, until they disappear, into the mainstream culture. The «Cultural Pluralism» model recognizes that contemporary societies are multicultural because different ethnocultural groups participate in the larger society, contributing to its development (Berry, 2006). Researchers have also expanded their approach from a «Melting Pot», with a general conception of immigrant's acculturation, to study diverse groups —like refugees, international students and workers, indigenous, or undocumented immigrants— and, of course, they also analyze the acculturation process of the host society (Ritter & Graham, 2017).

11.3. Acculturative Stress and Mental Health Management

Every immigrant or refugee can suffer **acculturative stress**. That is, a personal reaction to adapting to another culture. But the context also matters. A significant factor is the social position about cultural diversity, because a hostile community increases the probabilities of a stressful experience. Research has documented that a hostile environment boosts anxiety, depression, suicidal ideation, body disturbances and eating disorders. At the same time, improving educational levels and cognitive abilities decrease acculturative stress (Cuéllar, 2000).

Acculturative stress is a concept that describes difficulties and stressors that arise during the acculturative process, such as language differences, perceived cultural incompatibilities, and cultural selfconsciousness. Usually, acculturative stress studies focus on the differences between dominant vs. original cultures, but scholars also affirm that someone can suffer acculturative stress when the family criticize the youngest if they cannot speak their heritage language. So, acculturative stress has multiple sources (Crawford & Avula, 2014).

> *"Acculturative stress is more likely to occur when the host society's ideological stance is critical of pluralism and diversity and/or when members of the host society hold negative attitudes towards the immigrant group". (Teodorowski, et al. 2021)*

Language is an important factor in acculturative stress because it affects every family's member. The proficiency level of a new language marks the difference in the immigrant's professional development. Despite immigration being an exhausting experience itself, it is easier to get a job for a Latin-American that came to Spain, rather than for another one that does not have any knowledge of Spanish. In addition, for those who do not know the language of the host country there are diverse problems for different ages. 25% of children are dyslexic or have dysgraphia, so they suffer difficulties to write and read. Usually, the older and poorer do not know the language and confront more difficulties to learn it. During their working hours, most immigrant adults do not have contact with locals, making it more difficult for them to improve their language proficiency. Language is one of the most stressful factors, and researchers have demonstrated a clear association between insufficient proficiency and the underutilization of psychiatric services (Ohtani, 2015). However, mental health professionals tend to over-diagnose when there are communication barriers (Achotegui, 2019).

Another factor that impacts mental health is the length of time since migration. Some researchers affirm that acculturative stress is more frequent in poorer and recent immigrants, but the opposite theory sustains that those who immigrated more than 10 years prior are unhealthier than those who are living less than a decade in the new country (Crawford & Avula, 2014). Migrants usually feel this new life with a deep sensation of frustration and loss, and they could even develop an Acute Stress Disorder. Those who came from countries with a high incidence of unrest, wars, and civil conflicts may show high rates of Posttraumatic Stress Disorder or PTSD (Paniagua, 2013).

Immigrants frequently feel a deep sensation of loss. A grief for everything which they have left behind: family and friends, language, culture, homeland, and a social status that gives them a sense of belonging. Those immigrants must face up to dangerous journeys, accidents, or persecutions, so these physical risks reinforce the migratory mourning. The **American Psychiatric Association** (APA) in order to get an accurate diagnosis, recognizes how important the culture is to know the illness experience, to get an effective assessment, and an appropriate clinical

management. APA's framework for assessing information has demonstrated to be useful for clinicians and well accepted among patients. This model has five major categories:

- **Cultural Identity of the individual:** Describe how the racial, ethnic, or cultural reference group of a person relates to his/her relationships, use of resources, or conflicts with others. For immigrants and ethnic minorities, clinicians should note separately the degree and kinds of involvement with both cultures — original and host—. Language abilities, preferences, and patterns of use are relevant for identifying difficulties with access to care, and social integration. Other clinically relevant aspects of identity may include religious affiliation, socioeconomic background, personal and family places of birth and growing up, migrant status, and sexual orientation.
- **Cultural Conceptualizations of Distress:** The experiences, understandings, and communication of symptoms are described through cultural constructs, so mental health professionals have to write down the severity of experiences according to the norms of the individual's cultural reference groups. Assessment of coping and help-seeking patterns should consider the use of professional as well as traditional, alternative, or complementary sources of care.
- **Psychosocial Stressors and Cultural Features of Vulnerability and Resilience:** Mental Health Professionals have to identify significant stressors and support the role of religion, family, and social network in the person's emotional, instrumental, and informational help.
- **Cultural Features of the Relationship between the Individual and the Clinician:** One cause of difficulties in the therapeutic process could be the difference in culture, language, and social status between the professional and the

The Seven Migratory Mournings:
1. Family and Loved ones
2. Language
3. Culture
4. Homeland
5. Social Status
6. Belonging
7. Physical Risks

(Achotegui, 2019)

patient. The effects of this disconnection include the significance of symptoms and behaviors, and it is more difficult to have a significant relationship.

- Overall Cultural Assessment: To manage the intervention properly, it is important to summarize the implications of the cultural components identified above (APA, 2013).

Researchers have identified **Seven Forms of Migratory Mourning**. Beyond the mourning for language previously mentioned, immigrants also feel grief for family and loved ones. This is the most common cause of migratory stress, and it also has consequences for those who remain in the original country. Regularly, immigrants' children feel abandoned, and parents often feel guilty. The mourning for culture refers to values, food customs, dressing style, the way of enjoying free time, the world view or religion that immigrants practice. So, the concept of culture has a comprehensive perspective, it is very helpful to include the immigrant in social, culture, artistic or sport groups, as an important way of helping with the integration and elaboration of migratory grief. Immigrants also feel mourning for their homeland, usually when they come from warm and light countries and move to another colder and darker place. The mourning for social status is related with documentation, work, housing, access to opportunities etc. If within a few years after being expatriated, the immigrant does not improve this economical, social and legal situation, she/he feels a sense of demoralization and frustration. Additionally, being illegal is frequently associated with worse job conditions, like exclusion, exploitations, and racism. In this context, the poorer immigrants must accept more dangerous employment which has greater inherent physical risk, leading to workplace accidents. But it is not the only reason to suffer a migratory mourning for physical risks. Most of the poorer immigrants have done a dangerous migratory journey, have more domestic accidents because their houses have less security systems, they live in fear of being deported...

Fig. 15. Psychological Characteristics of Migratory Mourning (Achotegui, 2019)

To summarize, every day they have to confront physical, professional and emotional risks (Achotegui, 2019).

Although integration is the gold standard for good health, how much healthier cultural adaptation is, is not so clear. Researchers in the USA have found that people from developing countries suffer more cardiovascular diseases and are more prone to the abuse of psychoactive substances. Statistics correlate, however, higher socioeconomic status with lower rates of physical disease and mental disorders (Iwamasa, 2013). Despite the economy not being the only influential factor in an immigrant's health, it is the most prominent.

Everything changes for immigrants and refugees: diet, social and family relations, weather, language, status... So, resettling could trigger a deep grief. Poorer immigrants and refugees are the more exposed groups to develop patterns of symptomatology with a proper noun: Ulysses Syndrome.

11.4. The Ulysses Syndrome

> *"Kyklops, you ask me for my illustrious name and I'll tell you. Then you can offer me what a guest deserves, as you've just promised. No One is my name. They call me No One, my mother and my father and all of my friends".*
>
> *- Homer, song IX, 124*

Immigrants who have to face extreme situations develop a particular pattern of symptoms. This new syndrome's name is taken from the legendary Greek king of Ithaca described in Homer's Odyssey. An epic tale that describes the decade Ulysses' efforts to return home. Remembering one dangerous meeting with some Cyclops, and just to hide his identity, Ulysses answers «No One is my name». Immigrants exposed to extreme situations are more prone to suffer this Ulysses Syndrome. Like the Greek hero, they have to make themselves invisible just to survive. Without identity, neither options for social integration, they suffer a radical migratory grief in which all defense mechanisms fail. Depression and anxiety disorders appear, and this syndrome develops (Valero-Garcés, 2014).

Ulysses Syndrome's Symptomatology
- *Depression*
- *Anxiety-Related Disorders*
- *Somatic Symptoms*
- *Confusion*
- *Cultural Explanation*

This extreme mourning grief has a specific symptomatology, and the cultural interpretation of all these symptoms is an important issue. Among the most common indicators of depression, we can find sadness and crying. It happens that immigrants exhibit apathy, low self-esteem, guilt, or thoughts of death. They suffer insomnia, recurrent and intrusive thoughts, and irritability, so they are undergoing anxiety-related disorders' symptoms. Of course, they exhibit

somatic symptoms like migraine, fatigue, or articular complaints, and some signs of confusion, like disorientation, or depersonalization. Some affected immigrants blend these symptoms with expressions like «I must be cursed» or «I am the victim of witchcraft», and it is important that health practitioners understand that this is the way some patients can express his/her problem (Achotegui, 2019).

The syndrome can become chronic if the stressors do not disappear. These stressors may be related to loneliness, especially painful when the newcomer has left behind children and a spouse, to a deep sense of despair and failure when they cannot find conditions for a decent life in the new country, to fear of the physical dangers of the journey, of an uncertain future, to being immersed in the daily struggle for survival, and the threat of repatriation (Valero-Garcés, 2014; Achotegui, 2019).

In Spain, surveys on migrations have shown that migrants have progressively experienced increased levels of stress. But characteristics of Spanish migrations are international. The 21 century global economic crisis, together with the armed conflicts, persecution and poverty have altered the migration patterns. Most migrants have already experienced a huge level of stressors, mainly linked to violence, traumas and poverty in their native countries. After a forced separation from their families and homeland, immigrants faced with dangerous and, often, lethal migratory journeys. Those who survive are under stressors that go far beyond the usual adaptation mechanism when encountering new cultures. The fight for survival determines the development of this extreme migration duel. Under these circumstances, many of them often develop symptoms such as irritability,

nervousness, migraine, tension headache, insomnia, tiredness, fear, loss of appetite and generalized vague discomfort.

How many people suffer this syndrome is difficult to specify, since there are still just a few epidemiological studies. A Swedish paper related an increased risk of non-affective psychotic disorders among immigrants with a high frequency to exposure to social adversity before migration. This research showned that refugees were 1.66 times more likely to be diagnosed than migrants, because exposure to war and prosecution contribute to the increased risk of PTSD. The post-migratory factors in the host country, such as discrimination, racism, and social exclusion, also explain the high rates of psychotic disorder in some immigrants and refugees. Those researchers concluded that experiences of psychosocial adversities increase the risk of psychosis (Hollander, 2016).

In our time, the political and social context increase the psychosomatic disorders, and mental health professionals must be prepared to find concomitant illnesses. In 2015 the Migrant First Aid Centre in Genoa gave assistance to immigrants with a large variety of physical and psychological conditions. People with HIV, hepatitis B, gonorrhea, syphilis, tuberculosis and pregnant women received medical assistance, and psychological and psychiatric support when they needed it. After mental health intervention, people felt improvements in their quality of life and experienced a more positive attitude towards the new environment (Bianucci, 2017).

Some illnesses are simultaneous to mental conditions, but pain is a symptom itself. A recent observational study has explored the association between mental health and pain among undocumented migrants in France. Researchers found that 11.5% suffered anxiety, 15% had sleep disorders, 29.5% moderate to severe depression and the 16.2% had PTSD. They found, notwithstanding, that there are significant differences by gender: depression affects more women, while men suffer more sleep disorders. This study remembers that pain and mental illness share biological mechanisms and brain regions, so socioeconomically deprived people are more likely to have chronic and severe pain. This paper strongly associates chronic pain among undocumented immigrants with specific migration-related stressors, such as poor safety, poor physical environments, and poor access to healthcare. As a result, they recommend systematically asking questions pertaining to mental health when an immigrant patient is experiencing pain (Moussaoui, 2025).

European healthcare professionals must be aware that the current global humanitarian crises in the European Middle East, North Africa, and central Asia are adding to more displaced people, asylum seekers, and refugees worldwide than at any time since World War II. The immigrants ran away from social and economic surroundings in their original countries and, after, they were exposed to structural constraints in receiving countries. Those stressors increase the risk of common mental disorders and PTSD. Just as for the general population, refugees and their families will benefit from timely and early intervention and care, particularly in those exposed to severe psychosocial adversity.

References

Achotegui, J. (2000). Los duelos de la migración: Una aproximación psicopatológica y psicosocial. In E. Perdiguero & J. M.ª Comelles (Eds.), *Medicina y cultura. Estudios entre la antropología y la medicina* (pp. 83-100). Bellaterra.

Achotegui, J. (2019). Migrants living in very hard situations: Extreme migratory mourning (The Ulysses Syndrome). *Psychoanalytic Dialogues*, 29(3), 252-268. https://doi.org/10.1080/10481885.2019.1614826

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association.

Berry, J. (2006). Context of acculturation. In D., Sam & J., Berry (Eds.), *The Cambridge handbook of acculturation psychology* (pp. 27-42). Cambridge University Press.

Berry, J., Phinney, J.S., Sam, D. L., Veddre, P. (2006). Immigrant youth: Acculturation, identity, and adaptation. *Applied Psychology: An International Review*, 55(3), 303-332. https://doi.org/10.1111/j.1464-0597.2006.00256.x

Bianucci, R., Charlier, P., Perciaccante. A., Lippi. D., Appenzeller. O. (2017). The "Ulysses Syndrome": An eponym identifies a psychosomatic disorder in modern migrants. *European Journal of Internal Medicine*, 41, 30-32. https://doi.org/10.1016/j.ejim.2017.03.020

Brummett, B. (2019). Rhetoric of popular culture and representations of biomedicine. In A. Görgen et al. (Eds.), *Handbook of popular culture and biomedicine* (pp. 79-87). Springer. https://doi.org/10.1007/978-3-319-90677-5_7

Choy, B., Arunachalam, K., Gupta S., Taylor, M., Lee, A. (2020). Systematic review: Acculturation strategies and their impact on the mental health of migrant populations. *Public Health in Practice*, 2, 100069. https://doi.org/10.1016/j.puhip.2020.100069

Crawford, S., & Avula, K. (2014). Acculturation and health. In R. Gurung (Ed.), *Multicultural approaches to health and wellness in America* (pp. 99-123). Praeger.

Cross, W. E., Jr. (1991). *Shades of Black: Diversity in African-American identity*. Temple University Press.

Cuéllar, I. (2000). Acculturation and mental health: Ecological transactional relations of adjustment. In I. Cuéllar & F. A. Paniagua (Eds.), *Handbook of multicultural mental health* (pp. 45-62). Academic Press. https://doi.org/10.1016/B978-012199370-2/50004-3

Erten, E. Y., van den Berg, P., & Weissing, F. J. (2018). Acculturation orientations affect the evolution of a multicultural society. *Nature Communications*, 9, 58. https://doi.org/10.1038/s41467-017-02513-0

Hollander, A. C., Dal, H., Lewis, G., Magnusson, C., Kirkbride, J. B., & Dalman, C. (2016). Refugee migration and risk of schizophrenia and other non-affective psychoses: Cohort study of 1.3 million people in Sweden. *BMJ*, 352, i1030. https://doi.org/10.1136/bmj.i1030

Homer, (2023). *The Odyssey* (C. Underwood, Trans.). Hamilton Books.

Inglis, G., Sosu, E., McHardy, F., Witteveen, I., Jenkins, P., & Knifton, L. (2025). Testing the associations between poverty stigma and mental health: The role of received stigma and perceived structural stigma. *International Journal of Social Psychiatry*, 71(3), 554–563. https://doi.org/10.1177/00207640241296055

Iwamasa, G. Y., Regan, S. M. P., Subica, A., & Yamada, A.-M. (2013). Nativity and migration: Considering acculturation in the assessment and treatment of mental disorders. In F. A. Paniagua & A-M. Yamada (Eds.), *Handbook of multicultural mental health* (pp. 167-188). Academic Press/Elsevier.

Jager, W., & Paolillo, R. (2022). Towards a dynamic approach to acculturation. *International Journal of Intercultural Relations*, 89, 1–10.

Kirmayer, L. J., & Bhugra, D. (2008). Culture and mental illness: Social context and explanatory models. In N. B. Anderson (Ed.), *The Wiley-Blackwell handbook of the psychology of cultural diversity* (pp. 61–80). Wiley-Blackwell.

Kosic, A. (2006). Personality and individual factors in acculturation. In D. Sam & J. Berry (Eds.), *The Cambridge handbook of acculturation psychology* (pp. 113-128). Cambridge University Press.

Moussaoui, S., Vignier, N., Guillaume, S., Jusot, F., Marsaudon, A., Wittwer, J., Dourgnon, P. (2025). Pain as a symptom of mental health conditions among undocumented migrants in France: Results from a cross-sectional study. *International Journal of Public Health*, 69, 1607254. https://doi.org/10.3389/ijph.2024.1607254

Nolan, J. A., Whetten, K., & Koenig, H. G. (2011). Religious, spiritual, and traditional beliefs and practices and the ethics of mental health research in less wealthy countries. *International Journal of Psychiatry in Medicine*, 42(3), 267–277.

Ohtani, A., Suzuki, T., Takeuchi, H., & Uchida, H. (2015). Language barriers and access to psychiatric care: A systematic review. *Psychiatric Services*, 66(8), 798–805. https://doi.org/10.1176/appi.ps.201400351

Paniagua, F. A. (2013). Culture-bound syndromes, cultural variations, and psychopathology. In F. A. Paniagua & A-M. Yamada (Eds.), *Handbook of multicultural mental health* (pp. 25-47). Elsevier.

Piontkowski, U., Rohmann, A., & Florack, A. (2002). Concordance of acculturation attitudes and perceived threat. *Group Processes & Intergroup Relations*, 5(3), 221-232. https://doi.org/10.1177/1368430202005003003

Ramos-Villagrasa, P. J., & García-Izquierdo, A. L. (2007). La medida del síndrome de Ulises. *Ansiedad y Estrés*, 13(2-3), 253-268.

Ritter, L. A., & Graham, D. H. (2017). *Multicultural health*. Jones & Bartlett Learning. http://lccn.loc.gov/2015048787

Stuart, H. (2025). Mental illness and popular health. In C. S. Beck (Ed.), *The Routledge handbook of health communication and popular culture* (pp. 32-44). Routledge. https://doi.org/10.4324/9781003436409-4

Teodorowski, P., Woods, R., Czarnecka, M., Kennedy, C. (2021). Brexit, acculturative stress, and mental health among EU citizens in Scotland. *Population, Space and Place*, 27(6). https://doi.org/10.1002/psp.2436

Valero-Garcés, C. (2023). *Health, communication, and multicultural communities: Topics on intercultural communication for healthcare professionals*. Cambridge Scholars Publishing.

van der Zee, K., & van Oudenhoven, J. P. (2022). Towards a dynamic approach to acculturation. *International Journal of Intercultural Relations*, 88, 119-124. https://doi.org/10.1016/j.ijintrel.2022.04.004

Ward, C. (2001). The A, B, C's of acculturation. In D. Matsumoto (Ed.), *The handbook of culture and psychology* (pp. 411-445). Oxford University Press.

Yamada, A-M., & Marsella, A. J. (2013). The study of culture and psychopathology: Fundamental concepts and historic forces. In F. A. Paniagua & A-M. Yamada (Eds.), *Handbook of multicultural mental health* (pp. 3-23). Elsevier.

Final Reflection: Mental Health in a Multicultural Society and the EMPOWER Model

by Małgorzata Szkup

This chapter clearly demonstrates how **migration experiences, acculturation processes, and cultural differences** deeply influence the mental health of individuals from minority backgrounds. These insights are strongly aligned with the pillars of the EMPOWER model—particularly Multiculturalism, Wellness, Professionalism, and Effectiveness.

Topics such as **acculturative stress, the Ulysses Syndrome**, and **migratory mourning** highlight the need for integrated, culturally sensitive mental health care that goes beyond diagnosis to consider the **social, linguistic**, and **identity-based context** of each patient. This approach reflects EMPOWER's vision of **holistic, person-centered**, and **empathetic care.**

The chapter also provides practical guidance for **supporting migrants' mental resilience**, drawing on cultural assessment tools, acculturation models, and culturally grounded interpretations of symptoms. Additionally, it emphasizes the structural barriers—like language gaps, legal status, and access to services—that align with EMPOWER's call to reduce inequities and social exclusion.

In short, this chapter complements and strengthens the EMPOWER model, demonstrating that **effective mental health care in a multicultural society requires not only clinical knowledge, but also cultural competence, humility, and critical reflection**.

Multi Culti Med

Chapter 12

Religious, spiritual, and cultural practices related to health

MARZENA MIKŁA
University of Murcia (Spain)

It is valuable to have a general understanding of religious, cultural, and spiritual practices related to health; however, it is important to remember that this knowledge is not an absolute guide. Each patient is a unique individual who may nurture their traditions in different ways and have specific needs. The key to empathy and effective care lies in openness to dialogue and respect for personal beliefs, rather than treating general assumptions as unquestionable principles.

12.1. Introduction

This chapter explores cultural sociology, understood as the study of knowledge, customs, and experiences expressed in the behavior of individuals who live and interact within a group or community. It provides a cultural insight into the religious, spiritual, and cultural practices of communities related to health.

Cultural sociology is the study of knowledge, customs, and experiences expressed in the behavior of individuals who live and interact within a group or community.

Future healthcare professionals must acquire cultural knowledge to competently care for individuals from diverse cultures, religions, and ethnic groups in their professional practice.

Aims

Through this chapter students will enhance their attitudes, knowledge and skills in:

- Understanding the religious, spiritual, and cultural beliefs and practices of different religions, and their impact on healthcare decisions
- Recognizing the ethical and moral perspectives of these religious groups regarding medical procedures such as organ transplantation, euthanasia, contraception, and end-of-life care.
- Addressing potential challenges in healthcare delivery arising from religious beliefs and finding appropriate solutions to ensure equitable and inclusive medical treatment.
- Defining key concepts like sociology, culture, cultural sociology, religion, ethnicity, ethnic minority, stereotype, prejudice, generalizations.

Learning Outcomes

By the end of this chapter, readers will be able to:

- Explain the religious, spiritual, and cultural beliefs and practices of different religious groups and analyze their influence on healthcare decisions.
- Identify and evaluate the ethical and moral perspectives of various religious traditions on medical procedures such as organ transplantation, euthanasia, contraception, and end-of-life care. Recognize and address challenges in healthcare delivery related to religious beliefs, proposing solutions that promote equitable and inclusive treatment.
- Define and apply key sociological concepts, including sociology, culture, cultural sociology, religion, ethnicity, ethnic minority, stereotype, prejudice, and generalizations, in the context of healthcare.

Relevant Definitions and Terms

Sociology: Derived from the Latin socius ("partner") and -logía ("study"). It is the science that studies the structure and functioning of human societies. It analyzes

the mechanisms that shape interpersonal interactions and social organization, as well as the influence of social norms and institutions on the behavior of individuals and groups (RAE).

Culture: From the Latin cultūra ("cultivation"). It is a body of knowledge that allows an individual to develop critical judgment. It also refers to ways of life, customs, knowledge, and the levels of artistic, scientific, and industrial development in a given era, social group, or religious practice (RAE; Griswold, 2012).

Cultural Sociology: It is a branch of sociology that examines the knowledge, experiences, and customs that shape individual behavior within a given community over time. Groh (2019) points out that cultural sociology focuses on understanding how culture influences social structure and individual attitudes within larger social groups.

Religion: From the Latin religare ("to bind again") or relegare ("to read carefully again"), suggesting the restoration of the human-divine bond through strict adherence to established traditions. The Royal Spanish Academy (RAE) defines religion as a set of beliefs or dogmas concerning divinity, the feelings of worship and fear towards it, moral norms for individual and social behavior, and ritual practices, primarily prayers and offerings, as acts of worship.

Ethnicity: From the ancient Greek ἔθνος (ethnos), meaning "people" or "tribe," referring to a human community defined by racial, linguistic, or cultural similarities (RAE).

Ethnic Minority: A subgroup within a population that differs from the majority in terms of race, language, or religion (United Nations, 2018).

Social Determinants of Health: The conditions in which people are born, grow, live, work, and age that influence health outcomes and quality of life. There are five main social determinants of health: economic stability, access to education and its quality, access to healthcare and its quality, neighborhood and environmental conditions, and the social and community context (WHO, 2020; ODPHP; Koh, et al., 2011).

Stereotype: A widely held but oversimplified and often harmful belief about a specific group of people (Giger & Haddad, 2021).

Prejudice: A preconceived notion or judgment that is not based on sufficient knowledge. It can be either favorable or unfavorable. Negative prejudices can lead to stereotypes and discriminatory behaviors (e.g., racial prejudice) (Duckitt, 2014).

Generalizations: Statements about common cultural patterns. They often lead to misinterpretations, as descriptions of all individuals within a particular group, which in turn leads to the formation of stereotypes (Callender, 2015).

Spirituality: Statements that lead to a connection with something that gives life meaning and supports personal growth. Spirituality also contributes to the development of values and positive inner emotions. Within the proposed model, the authors identify three main dimensions of spirituality:

- Beliefs, practices, and experiences that initiate a spiritual connection.
- Objects of connection, such as God, nature, community, art, the afterlife, spiritual beings, or the inner self.
- Outcomes of spirituality, including values, personal growth, meaning in life, well-being, and a sense of inner peace.

This definition encompasses both theistic and secular approaches, recognizing the cultural and individual diversity of spiritual experiences in the context of healthcare (de Brito Sena, et al. 2021).

12.2. A Brief Guide to Cultural, Spiritual and Religious Practices Related to Health

Future healthcare professionals will encounter individuals from diverse cultural and religious backgrounds in their work. Recently arrived patients in Europe, including immigrants, representatives of ethnic minorities such as the Roma, as well as religious groups such as Jehovah's Witnesses, along with patients from majority groups adhering to major religions such as Catholicism, Islam, and Hinduism, form a population to which healthcare workers and the healthcare system must provide high-quality care. The challenge lies not only in overcoming language barriers but also in understanding their worldviews, attitudes, and values, in order to prevent unequal treatment of any minority group. To address health inequalities, it is essential to equip future healthcare professionals with the necessary competencies and knowledge.

In Europe, the major Christian religions, particularly Catholicism, Orthodoxy, and Protestantism, are the most widespread. In 2018, approximately 70% of the European population identified as Christian (Pew Research Center, 2018).

12.2.1. Catholicism

Is one of several Christian denominations. According to the Center for the Study of Global Christianity, in 2022, there were 2.4 billion Christians worldwide, of which 1.36 billion were Catholics (Center for the Study of Global Christianity, 2022). Catholicism, in its full scope, is defined as a doctrine of faith revealed in the Bible and tradition, the institution of the Church and its office, worship, liturgy with sacraments, Christian morality, religious practices and life, and the openness of the believer to divinity and all higher worldly values (Pawlak, 2002).

Institutionally, Catholicism is organized under the leadership of the Pope, who is regarded as the head of the Church and the successor of Saint Peter. The Ten Commandments serve as moral and religious principles governing human conduct. The Catholic Church believes that life and physical health are precious gifts entrusted by God and must be cared for, always considering the needs of others and the common good. Although physical life is part of the transcendent value of a person, it inherently reflects the temporality of human existence, which becomes evident through illness and suffering. Christians view illness and suffering as a path to salvation. While they must respect physical life, they should not consider it an absolute value, opposing the spread of the so-called "cult of the body." Catholics are encouraged to avoid all forms of excess related to food, alcohol, or drugs.

The Catholic Church supports organ donation and transplantation as acts of solidarity. However, it holds a negative stance towards artificial insemination, in vitro fertilization, post-mortem fertilization, and surrogacy (Donum Vitae, 1987). Church teachings affirm that all sexual activity achieves its true meaning and moral dignity only within marriage. The Catholic doctrine clearly prohibits any procedures related to abortion (Evangelium Vitae, 1995).

Death signifies the end of human life on Earth but, for Christians, represents the transition to eternal life. It is the beginning of a transformed existence. During the dying process, religious symbols such as a crucifix, images of saints, or medals worn on the wrist or hung on a chain around the neck may be seen beside the dying person. Hospital spaces should be adapted so that the family can accompany the patient in their final moments. Direct euthanasia is prohibited; however, the cessation of per-

sistent therapy is permissible. Palliative care and sedative therapy are applied to ensure the best possible quality of life in the patient's final days (Samaritanus Bonus, 2020). Cremation and autopsy procedures are permitted.

The Catholic Church regards motherhood as a mission of exceptional responsibility and service to life. A pregnant woman must receive comprehensive support from her family and religious community. After childbirth, the mother dedicates herself to the care andfeeding of the child. If the health or life of the child is at risk, any necessary medical interventions to protect the child are permitted. The right to protect the child's life reflects the Church's commitment to care—every child deserves to be treated with love, tenderness, and understanding (Majda, et al., 2009).

12.2.2. Orthodox Church

The Orthodox Church's faith is rooted in tradition, which affirms the need to remain faithful to the spirit of the early Church. The most important source of faith is the Holy Scripture (the Bible). The Orthodox Church bases its teachings on the Greek translation of the Bible, believing that this text was written under the inspiration of the Holy Spirit.

Sacraments (mysteries) accompany individuals during the most important and significant moments of life, serving as participation in divine grace. These include baptism, chrismation (confirmation), the Eucharist, confession (penance), ordination (priesthood), marriage, and holy function (anointing with blessed oil). One significant ritual in the Orthodox Church is the anointing with oil, previously blessed by a priest. This sacrament heals the soul, mind, and body and can be administered to anyone in need—whether for physical or mental healing, or as preparation for death (Pruszynsk & Grabowska-Grzyb, 2007).

Icons hold a special place in the life of every Orthodox believer. In Orthodox tradition, an icon is an object of veneration, painted (Orthodox followers say "written" rather than "painted" icons, considering them a form of prayer and a way to convey truths of the faith, rather than merely a work of art) using Byzantine techniques, representing the presence of grace and the sacramental sign of God's invisible presence (Gwynn, 2007).

The attitude of Orthodox believers towards health, illness, and death is similar to that of other Christian denominations. They view illness as an act of God that can help a person draw closer to Him and receive special grace to help others. Death is seen as a transition to eternal life. Orthodox Christians consider providing assistance and support to the sick as a natural part of life. The Orthodox Church does not oppose organ donation and transplantation. However, some Orthodox believers may be reluctant to donate organs due to their belief in the resurrection of the body. This may be interpreted as desecration of the body and could prevent or complicate organ donation (Iglesias, et al., 2023).

In comparison to Roman Catholicism, the Orthodox Church is more liberal regarding the use of contraceptives. It treats abortion as murder. The use of euthanasia is unacceptable.

In the care of a dying patient, it is essential to provide support and the presence of another person so that the patient does not feel alone and abandoned. Pain relief is administered through analgesics. The deceased bid farewell with a kiss on the forehead.

It is important to ensure contact with an Orthodox priest for the reception of sacraments, such as confession, the sacrament of anointing of the sick, or Holy Communion. After death, the body is washed and elegantly dressed. The funeral service is held on the third day after death. In the care of adults and children, there are generally no special needs specific to this religion. All life-saving and health-restoring treatments are permitted. A woman may receive Communion during pregnancy and breastfeeding. After childbirth, a woman should fast according to the guidelines, as other members of the Church do. As with any other case, religious customs should be followed according to the patient's needs (Majda, et al., 2009).

12.2.3. The Greek Catholic Church

Refers to several Eastern Catholic Churches that maintain a close relationship with the Roman Church while adhering to the Byzantine or Greek rite. This Church acknowledges the authority of the Pope and Catholic dogmas, yet preserves its independence in terms of canonical law, diocesan organization, liturgy, clergy's right to marry, and the Julian calendar. The differences between the Greek Catholic and Eastern Orthodox Churches relate to dogmas concerning the primacy of the Pope, the origin of the Holy Spirit, Purgatory, and the Assumption of the Blessed Virgin Mary.

The Church's stance on health, illness, and death is similar to that of other Christian denominations. Health and life should be supported at every stage. The faithful observe fasts that involve limiting the number of meals or abstaining from certain foods, such as meat or dairy products. Greek Catholics, like Orthodox and Catholics, support organ donation, organ transplants, and blood transfusions. These procedures must always be performed with respect for both the donors and recipients. The Greek Catholic Church condemns marriages that avoid procreation and use contraception. It condemns abortion as an act of murder. In the

care of pregnant and postpartum women, newborns, sick children, adults, and patients in the final stage of life, there are no substantial differences compared to other Christian religions. Pregnant women and those who have given birth are exempt from fasting if medically required. In cases where the life and health of the child are at risk, all medical actions necessary to maintain the child's life and health, in line with current knowledge, are permitted.

At the end of life, the sacrament of the sick is administered, which lasts much longer than the sacrament provided in Catholicism. After blessing the oil, the priest prays, reads excerpts from the Gospel, and makes the sign of the cross, anointing the forehead, nose, ears, chest, hands, and feet of the sick person, repeating this action seven times. The Bible is presented to the sick person for kissing. (Majda, et al., 2009; Fouka, et al., 2012).

12.2.4. Protestantism

Is one of the branches of Christianity, alongside Catholicism and Orthodoxy. It consists of three religious groups: Lutheranism, Calvinism, and Anglicanism, originating from Martin Luther's Reformation in the 16th century. Luther emphasized the direct relationship between the believer and God, questioning the necessity of sacramental mediation and liturgy. The understanding of the Bible is the key difference between Protestantism and Catholicism. Protestantism emphasizes religious individualism and the role of subjective religious conscience.

Martin Luther

Protestant believers accept only two sacraments: Baptism and Eucharist; they do not practice individual confession; reject the cult of Mary, saints, indulgences, and relics. The contemporary Protestant Church is fragmented, as it believes it cannot identify with any institutionalized church. Among Protestant churches are Baptists, Methodists, the Pentecostal movement, and the Seventh-day Adventist Church. With the exception of the Seventh-day Adventists, the lifestyle of Protestants does not significantly differ from that of Catholics. Many free Protestant

churches have strict fasting rules. Seventh-day Adventists do not smoke, drink alcohol, or use drugs, including strong coffee and tea. A vegetarian diet is recommended, although beef, lamb, venison, and poultry, such aschicken and turkey, are permitted. A key aspect of Protestant life is work, viewed as a vocation and a human duty. It rejects a consumerist approach to life and the secularized culture of leisure.

Protestants accept organ donation, organ transplants, and blood transfusions. Most Protestant churches do not recommend artificial insemination, but they do not reject it either. The Pentecostal Church does not allow any form of genetic manipulation, while the Seventh-day Adventist Church permits artificial insemination only if the genetic material comes from a married couple. In Protestantism, abortion is considered a sin, but the Church does not impose a single solution on its followers; the decision of the mother or the couple should be respected. Active euthanasia is not accepted, but the decision to limit therapeutic efforts is differentiated and separated from euthanasia. Care for a patient in the final moments of life should take into account the differences arising from belonging to a specific religious community. Differences, for example, arise when a newborn in critical condition can be baptized with the parents' consent. This practice is permitted in the Evangelical Lutheran and Methodist Churches. The care of a pregnant woman, a postpartum woman, a newborn, or a sick child does not require any special actions beyond those commonly accepted and practiced in current healthcare. (Majda, et al., 2009; Swihart, et al., 2023).

12.2.5. Judaism

The Jewish religion dates back to the second millennium BCE. Judaism is not a revelation, doctrine, or teachings of an inspired master (as in Buddhism, Catholicism, or Islam), but rather the result of a slow, collective creation, involving fig-

ures such as Abraham, Jacob, David, and the prophets of Israel. From ancient times to the present day, the Bible remains the foundation of life, thought, and worship in the Jewish religion. The Hebrew Bible is a vast literary work consisting of three parts, the most important of which is the Torah. In order to make it accessible to the faithful, an extensive commentary known as the Talmud was written. Despite significant dispersion worldwide, Jews have remained faithful to their religion. However, many do not strictly observe the commandments of their faith. Today, only about ten percent of Jews practice traditional Judaism, known as Orthodox Judaism. This branch considers the Hebrew Bible to be inspired. Conservative Judaism, however, disagrees with this view, claiming that the Torah (the holy book of Judaism) was invented by rabbis attempting to adapt Judaism to the new era. Reform Judaism is the most liberal and rejects most traditional religious practices. Rabbinic writings treat the human being as an inseparable whole of body and soul.

A person is morally obligated to care for their body. Food must be kosher, prepared according to rules derived from Jewish laws and regulations based on those written in the Torah. Orthodox Jews strictly observe these rules. In Jewish communities, there are associations where members care for the sick and dying (men care for men, and women care for women). There is an obligation to care for those who suffer, and neglecting this is considered a lack of virtue. The Sabbath is the seventh day of the week, falling on Saturday, and its observance begins on Friday evening with the lighting of candles. All paid work is prohibited, and there are exactly 39 forbidden activities that cannot be performed during the Sabbath. Jews accept organ donation, organ transplants, blood transfusions, and artificial insemination within marriage. They allow the use of oral and intrauterine contraceptives. They oppose abortion, but each case is treated individually. Reform Judaism accepts cremation and autopsies; Orthodox Jews oppose them. Jewish law rejects any means to shorten human life and is against euthanasia.

Jewish tradition requires special care for pregnant women; they are not obligated to fast, but it is their duty to cooperate with medical personnel and undergo all recommended medical examinations. After childbirth, women are ritually unclean for seven days in the case of a male child and for fourteen days in the case of a female child. Women in some branches of Judaism cover their heads in public places, including in hospitals. When admitted to the hospital, it should be ensured that the patient has disposable plates and cutlery, as required by the need for food segregation. If necessary, family members should be allowed to bring food from home, and if this is not possible, a vegetarian diet should be provided. Boys are circumcised eight days after birth. Care for Jewish children is the same as in other religions and among atheists. All vaccinations are performed according to the vaccination schedule. In Jewish tradition, children reach maturity and begin to be treated as adults when they turn 13 (boys) or 12 (girls).

For Judaism, human life is of the highest value. Patients are responsible for their health and actively cooperate with medical staff to recover. Families often care for patients in the hospital, for example, attending to hygiene to protect the patient's

privacy. Orthodox Jews follow the principle of not touching members of the opposite sex. However, in cases of serious illness, all restrictions are lifted. If the patient's condition significantly worsens, the family must be allowed to stay with the patient, even if the family is large. Family members encourage the seriously ill patient to reflect on their conscience. After the death of a patient, the body is ritually prepared in a specially equipped room, never in the hospital. The presence of the deceased's body is a source of impurity, and touching it requires the ritual washing of hands as a sign of spiritual purification (Majda, et al., 2009; Gabbay, et al., 2017).

12.2.6. Islam

Is the youngest monotheistic religion, founded in the 7th century. Its sacred scripture is the Qur'an, which contains revelations delivered to humanity by the Prophet Muhammad in the Arabic language. The Qur'an comprises doctrinal statements, principles concerning religious worship, moral norms, guidelines for appropriate behavior, dietary laws, civil and criminal law, international law, and religious narratives. The entire Muslim culture and civilization is based on it. In addition to the Qur'an, the source of knowledge is also the Sunna, the tradition of Prophet Muhammad, which consists of hadiths—records of Muhammad's behaviors, sayings, decisions, and actions—offering a model for imitation (Szopski, 2005). The fundamental principle of Islam is loyalty to religion and God. Prayer is a very important element; it is a form of veneration and praise of God. Every Muslim must pray five times a day, standing in a clean place, such as on a prayer mat, facing the direction of Mecca, the holy city of Islam. Almsgiving is another symbolic practice that expresses readiness for sacrifice in the name of religion. Fasting involves refraining from eating and drinking for 30 days, from dawn until dusk, during the month of Ramadan. Meals are only allowed before dawn and after dusk. Fasting is an obligation for every adult Muslim. Fasting may be broken if the person's work is physically demanding or if there is a concern that fasting may harm the individual or others. Every Muslim is required to make a pilgrimage to Mecca.

Muslims form the second-largest religious community in the world (after Christianity). In Europe, Islam is the fastest-growing religion, with the largest increase in followers, not only due to the influx of immigrants but also due to a high birth rate and conversions.

Islam emphasizes the importance of maintaining health. Preventive measures include fasting, prayer, ritual body washing, almsgiving,

and marriage, as well as prohibitions such as drinking alcohol, smoking, using drugs, adultery, gambling, and consuming pork. The Muslim family is patriarchal. The Muslim religion imposes no restrictions on organ donation or transplantation. Blood transfusions and blood products are permitted and accepted.

Islamic law accepts methods of artificial insemination when used within the context of marriage. In different Muslim countries, there are various opinions on the use of contraceptive methods; in some countries, they are allowed if they serve to protect the health of women. In the Qur'an and Sunna, abortion is prohibited after the 120th day of pregnancy, although opinions on this issue vary; in some countries, abortion is entirely forbidden. Islam opposes cremation, as the body after death should be arranged in such a way that the face is turned towards Mecca. Autopsies are allowed only for medical and legal reasons. Euthanasia is condemned, but it is advised to refrain from artificial lifeextending methods. During the postpartum period, a woman does not fast, engage in sexual activity, or pray, but focuses on recovering her strength. Breastfeeding for two years is recommended. Muslim women often are reluctant to undergo gynecological examinations if the physician is a man. In Islamic culture, there is no tradition of family childbirth (Leong, et al., 2016).

The birth of a child is a great joy for the family. As soon as the midwife cuts the umbilical cord, the newborn should hear the word adhan (call to prayer) whispered into their ear. Locally, there are various traditions, such as bathing the baby four times after birth or placing a chewed date in the baby's mouth. Circumcision, performed on boys from the seventh day until the age of 15, is a practice still observed today. All vaccinations, life-saving procedures, and blood transfusions are permitted. Muslims often use natural medicine, such as herbal medicine, apitherapy, homeopathy, and psychotherapy, to complement conventional medicine.

In Islam, there are no sacraments like those in Catholicism, such as confession, penance, or anointing of the sick. Muslim tradition requires that the immediate family members sit with the dying patient, touch them, and pray together. The word "God" should be the last word spoken by a Muslim. The first action after death is ritual purification, performed by someone of the same gender. The deceased is wrapped in a shroud and placed in the grave without a coffin, although in European countries, Muslims bury their dead in coffins (Ordys & Eszyk, 2007; Majda, et al., 2009; Almansour, et al., 2017).

12.2.7. Hinduism

Is currently one of the largest religious systems in the world in terms of the number of followers. It is practiced by over a billion people, primarily in India. Almost every region has its own customs, beliefs, god worship practices, traditions, and rituals. The worship of gods is vibrant, with statues decorated with flowers and fruits, and worshippers singing hymns and litanies. The position of an individual in the caste system depends on their origin, qualifications, and type of work. There are four basic social groups: Brahmins, Kshatriyas (warriors), Vaishyas (merchants and farmers), and Shudras (laborers). There are also people who do not belong to any caste, known as "untouchables," who occupy the lowest position in Indian society.

A pilgrimage to the Ganges River for a ritual bath is of great significance to many Hindus. Its purpose is to eliminate the negative effects of karma. The growing interest in Hinduism in Europe is linked to its beliefs and traditions, vegetarianism, yoga, and elements of Ayurvedic medicine.

Concepts of health, illness, and death in Hinduism are based on religious, philosophical, and magical foundations. Since the destiny of all beings depends on previous incarnations, all manifestations of happiness and misfortune, good and evil, prosperity, illness, and suffering can be interpreted as direct consequences of actions in a past life. One can avoid illness through prayer, dedication, and various religious practices. Conversely, the negative consequences of bad actions committed in a previous life can be reduced or even eliminated by leading a virtuous life in accordance with practices developed to free oneself from the cycle of reincarnation, such as asceticism and yoga, which aim to neutralize the factors affecting the "wandering soul." To achieve this goal, one must isolate oneself from society, fast, mortify the body, and meditate. In Hinduism, health is viewed as synonymous with life.

The natural medicine system called Ayurveda has moved away from magical and religious approaches to health and seeks to rationally explain health problems. The ultimate goal of life in Hinduism is to ascend to higher levels in the hierarchy of being, which is why death is not considered a negative event. To prepare for death, one must undertake a pilgrimage to Varanasi, a place of ritual purification located on the left bank of the Ganges River. It attracts many sick and dying individuals and is also a site for ritual suicides (Arora, 2024).

Organ transplantation is viewed positively because it extends the life of another person, thereby allowing them to fulfill their karma. Blood transfusions are also permissible. However, there are conflicting opinions, with some arguing that any

attempt to artificially extend life traps the soul in the old body, disrupting the natural cycle of birth and death.

Artificial insemination is accepted in Hinduism. The most important value in Hinduism is family. Having children and family planning are linked to the sexual and erotic spheres, which occupy an important place in Hindu culture. Attitudes toward sex, contraception, and family planning vary depending on the sect of Hinduism. Abortion is seen as a cause of bad karma and may lead to a fall to a lower level in the hierarchy of beings.

The birth of a child is an important event. Often, Hindu women, regardless of their health and financial situation, wish to become pregnant because it frees them from heavy household duties and physical labor. Pregnant women are subject to many prohibitions, including avoiding fasting, losing weight, and traveling. Their husbands may accompany them during childbirth. They may give birth naturally or through a cesarean section. The mother must rest for 40 days after giving birth. Inability to bear children, miscarriage, or loss of a child may be viewed as punishment for the woman, leading to poorer treatment by her relatives. After the birth of a child, a ceremony is often held in many families to drive away evil spirits.

The quality of healthcare in India depends on the patient's origin, educational level, profession, and, most importantly, their economic situation. High-class hospitals are accessible only to those with the necessary financial resources, which is why some immigrants from India may find themselves in a hospital for the first time in Europe, as care for the poor is typically provided only at home or in nursing homes.

In Indian culture, an autopsy is seen as a transformation of the soul's consciousness, which, after death, separates from the body to take on a new material form. Another factor influencing the cycle of birth, life, and death is cremation, one of the oldest Hindu customs associated with death. The body must be burned to achieve liberation. Cremation is primarily a form of purification. Euthanasia is seen as death by choice and an escape from life and its associated suffering. In India, passive euthanasia is allowed; food and water are withheld at the patient's request. The approach to persistent life-sustaining treatment is clearly defined: when the brain loses its activity, the body's functioning should not be artificially maintained.

The final stages of life involve continuous preparations for death. Temporal matters must be resolved. People from lower castes are cared for by their relatives at home, but it often happens that sick and exhausted individuals die on the streets without assistance. In higher castes, patients in the final stage of life receive care in hospitals. Caregivers maintain contact with the patient until death but try not to touch the body—according to tradition—as the body is considered impure. There is a g roup of specialized individuals who professionally care for the deceased for a fee. After death, the body, wrapped in a thin cloth, is placed on a funeral pyre (sandalwood for wealthier castes and sun-dried cow dung for the poor), covered with flowers, and set alight by the eldest son; if the deceased is a woman, the fire is lit by her husband or younger son. After the body is cremated, the ashes are thrown into the sacred Ganges River or a lake (Majda, et al., 2009; Chakraborty, et al., 2017).

12.2.8. Buddhism

Buddhism emerged as a religious system in the 6th century BCE in India. The founder of Buddhism, the Buddha "The Enlightened," Siddhartha Gautama, renounced his luxurious and comfortable life to practice asceticism, which he later abandoned in favor of attaining enlightenment—understood as freedom from the continuous cycle of birth, death, and suffering. One hundred years after the death of the Buddha, the movement split into two main branches: the Hinayana and the Mahayana. The former focused on the study of the Buddha's texts, while the teachings of the Mahayana branch primarily centered on the understanding of emptiness and the Nature of the Buddha. In their spiritual practice, they developed the capacity for loving-kindness, understanding the nature of reality, and deepening knowledge of the Buddha's nature. The second branch gave rise to the Vajrayana practice, which spread to Tibet (forming the foundation of Lamaism) and parts of China.

It is important to accumulate karma (merit) through actions motivated by love, compassion, and gratitude. Money, titles, and family—these all vanish when we die. Buddhist philosophy does not refer to the concept of a Creator but instead believes in the law of cause and effect, understood as the result of positive and negative actions. Spiritual development aimed at cultivating kindness, love, compassion, wisdom, and eliminating the three fundamental poisons of the mind—desire, anger, and ignorance—leads to enlightenment and breaks the cycle of rebirth and death. Birth, illness, old age, death, or contact with something that does not bring pleasure is considered suffering. Freedom from suffering can be attained by overcoming negative emotions such as anger, jealousy, hatred, desire, and false self-esteem.

In Buddhist medicine, there are four categories of disorders (diseases). The first category includes illnesses arising from karma accumulated in past lives; the second includes diseases originating early in life; the third is caused by spirits; and the last results from poor diet or improper behavior. Tibetan medicine also addresses chronic diseases, including cancer. (Bauer-Wu, et al., 2014).

Buddhism is generally supportive of blood transfusions, organ donations, and transplantation—giving an organ to someone will bring positive results in the next incarnation. Different Buddhist sects hold various positions on family planning and contraception. In practice, there is a recognition of the need for these methods. Currently, the methods accepted by Buddhists include oral contraceptives, condoms, diaphragms, sterilization, and natural methods. Buddhism accepts assisted reproduction, though it views it as an attempt to influence karma, i.e., the life path for the next incarnation.

According to Buddhist tradition, human life begins at the moment of conception. In traditional Buddhist schools, abortion is considered illegal and is only permissible if the mother's life is in danger. There have been exceptions to this rule in history, such as in post-World War II Japan, where abortion was practiced to reduce birth rates (mabiki rituals and mizuko kuyo). Buddhism accepts cremation and does not oppose autopsy, focusing on consciousness rather than the human body. Buddhism strongly opposes euthanasia as it leads to the accumulation of negative karma.

Buddhism places great importance on having children. A pregnant woman must care for her physical and mental health. Positive thinking and religious practices are essential. Proper nutrition, rest, adequate sleep, walks, and avoiding heavy work are recommended for expectant mothers. Medical care, a calm environment, and surrounding oneself with honest people facilitate childbirth and reduce negative emotions associated with pain. Postpartum, women may participate in all religious practices. Typically, they breastfeed their children for at least a year. Traditionally, a horoscope is drawn for every newborn. All people who come into contact with the newborn on its first day of life should be kind to it. At the request of the parents, the Dalai Lama selects the child's name while still in the womb.

The healing process for an adult involves following dietary recommendations, including the elimination of foods that disrupt the body's balance. The patient must take herbs prescribed by the doctor. Recovery in Buddhist understanding is possible if religious practices are combined with spiritual practices, such as meditation, and physical practices, such as lifestyle changes, for example, abandoning addictions.

Death in Buddhism is considered the most important moment in life, and its course is divided into stages. According to Buddhist philosophy, the body consists of the elements of earth, water, fire, air, and space, which create and sustain the body until death. The external decomposition begins when sensory activity ceases, and strength and energy are lost. Control over physiological functions and the ability to perceive physical sensations fade. Heat loss occurs, and the perception

of external stimuli changes. In the phase of the disintegration of the air element, breathing disturbances appear, and the person loses contact with the material world. Depending on the life lived, visions of all negative events and fears arise. If the person lived a good and compassionate life, they will encounter loved ones and experience heavenly visions. The environment of the sick person should be calm. Family and friends should evoke feelings of love, compassion, and devotion. Direct presence of loved ones is not recommended, as despair may disrupt the calm of the dying person. The most important support is the presence of a spiritual guide. The position of the body at the time of death is also significant. Traditionally, it is recommended that the dying person be placed on their left side in the "sleeping lion" position. This position is intended to facilitate the recognition of luminosity, which appears after death and helps the consciousness leave the body. A great help for the dying person is the practice of phowa, which involves visualizing rays of light flowing toward the dying person and cleansing them. It is best to perform phowa before touching or moving the body. This practice should be continued for three weeks after death. Funeral customs in Buddhism vary and depend on the region or country. In Thailand, the body of the deceased is taken to a monastery, washed, and cremated on a day determined by the horoscope. In Tibet, the body is wrapped in white cloth, cut into pieces, and left to be consumed by birds without leaving any trace. The bodies of respected members of the community are often burned on a pyre (Majda, et al., 2009; Khoo, 2023).

12.2.9. Jehovah's Witnesses

Was founded in 1872 by Charles T. Russell in Pennsylvania, USA. For Jehovah's Witnesses, the Bible is a sacred text, considered the inspired word of God, holding the highest authority in their religious beliefs and practices. According to their convictions, the Bible contains God's will, laws, moral principles, and the plan for humanity's salvation. Jehovah's Witnesses do not isolate themselves from society but live and work within it; however, they refrain from engaging in politics or military service, as they believe these actions contradict biblical teachings. They do not participate in ecumenical events, reject traditional religious rituals, and only observe the annual commemoration of the death of Jesus Christ, which occurs around Easter. Baptism is performed by full immersion in water and is conducted for individuals who are mature enough to make this decision consciously and independently. Jehovah's Witnesses are extensively involved in evangelism. They do not establish strict guidelines regarding customs, do not celebrate holidays or birthdays, consume very little alcohol, and avoid foods containing animal blood.

Jehovah's Witnesses are committed to maintaining their life and health as a gift from God. Therefore, they approach medical treatment with great awareness, discipline, willingly cooperating with medical staff and diligently ensuring the effectiveness of their treatment. However, Jehovah's Witnesses reject all forms of blood transfusion. This position began to be advocated after 1945. Since then, both adults and minors who are Jehovah's Witnesses are prohibited from consenting to blood

transfusions. This extreme stance has led to numerous studies aimed at providing alternative blood replacement therapies and developing protocols for treating critically ill patients without blood transfusions (Villarejo, et al., 2007; Tayloret, et al., 2020). In the case of newborns, infants, or children, the decision regarding a transfusion is made by the parents, with the father having the final say if there is a disagreement between the parents. It is important to note that from the perspective of both law and medical ethics, the life of the child is paramount and takes precedence over the protection of religious beliefs and the personal freedom of the parents. If a doctor perceives no alternative therapeutic option, they may seek a judge's intervention, who may, under certain circumstances, revoke parental rights for the duration of the treatment. All actions must be transparent and cannot be concealed from the parents.

Jehovah's Witnesses have a positive stance toward organ donation and transplantation. The Bible does not explicitly forbid receiving organs and tissues from other individuals, aside from blood. Each member of the congregation makes a personal decision about organ transplantation in accordance with their conscience (Cummins & Nicoli, 2018). Euthanasia is explicitly condemned, as it is incompatible with biblical teachings. For Jehovah's Witnesses, life begins at conception, and therefore abortion is not accepted. Neither the threat to the mother's health, nor the discovery of fetal genetic defects, nor cases of rape or incest, justify abortion. The Bible does not condemn birth control within marriage; the couple may choose contraceptive methods as a personal decision. It is essential to avoid substances that may harm the developing fetus.

For Jehovah's Witnesses, funerals are an occasion to express religious beliefs. Their belief in resurrection prevents them from expressing sorrow or grief over the deceased. Jehovah's Witnesses do not attach religious significance to funerals. Autopsies are only permissible when required by law (Majda, et al., 2009; Swihart, et al.,2023).

12.2.10. Roma

Are the most diverse and currently the largest ethnic group in Europe, with ancestors who likely originated in India and began migrating to Europe as early as the 6th century. They do not have their own state or defined territory. Due to migration and contact with other cultures, people, languages, customs, and religions, they have become highly diverse. Since ancient times, the Roma have been involved in ironworking, metal production, juggling, dancing, and fortune-telling. Everything related to the Roma and their culture has been passed down orally. Today, the Roma are divided into various subgroups, spread across all continents. These include the Calós, Sinti, Kalderash, Doms, and Romanichels. Most Roma are Christians, some are Muslims, and others maintain their faith in Hinduism. One of the most distinctive features of their social behavior is their solidarity within the group and tolerance. All aspects of Roma life are governed by an unwritten code of moral laws and prohibitions, which evolved from tradition and centuries of experience (Gypsy law). Failing to adhere to these rules may result in consequences such as "banishment," or expulsion from the group. The Roma divide the world into "our" and "other, non-Roma." They draw from elements of the "other" world to meet their needs, using hospital services in cases of childbirth, illness, or death. In many cases, they resist prolonged hospitalization and regard surgical procedures as highly dangerous. In some Roma groups, there is a belief that the larger a person is, the happier and healthier they are, which often results in obesity, while a slim physique is seen as a sign of illness or poverty (Majda, et al., 2009; Poveda, et al., 2014; Krasnowolski, 2022).

Health care is often not viewed as one of their highest priorities in Roma communities. In many cases, organ donation and transplantation are considered procedures they do not trust and reject. Most prefer not to discuss death or organ donation after death. They accept blood transfusions to save their lives (Rios et al., 2023). In vitro fertilization is not permitted. Infertility is a taboo subject, as is contraception, and Roma often do not wish to discuss these topics.

Abortion is considered a sin; it is understood as the deliberate killing of a Roma child and is strictly prohibited. The foundation of Roma existence is the family, which is typically large, multi-child, and very extended. Life revolves around this social unit. The birth of the first child is particularly awaited; its absence is seen as a punishment for sins. Childlessness among the Roma leads to so-called internal adoption, in which another married couple gives their newborn to a childless family. Pregnancy outside of marriage is seen as a crime, resulting in the loss of honor and respect, and may lead to disputes between families. The subject of childbirth is

taboo, and it is not discussed. Currently, most births occur in hospitals. Hospitalization helps isolate the birthing woman from the Roma community. Roma women prefer female staff care. The father is never present at the birth. He often waits outside the hospital until the birth is over, appearing briefly only to see his child. After returning home, the mother is isolated in her home. The mother or mother-in-law handles domestic duties. This isolation lasts up to six months. The newborn also has limited contact with the father and grandfather, who often do not touch the grandchild for the first three months of the child's life.

The Roma reject cremation. They may accept an autopsy if it is a judicial procedure. They do not accept euthanasia. The solidarity of the Roma community is most evident during the illness and death of a family member. A large group of close relatives gathers to vigilantly care for the sick and dying. Today, Roma predominantly die in hospitals. Crying and wailing are part of the behavior associated with death among the Roma. (Kozubik, et al., 2019)

The Roma treat the deceased with great respect, and their memory is honored. According to tradition, they should die away from their place of residence; in the past, the bed was carried out of the home. The closest family should be present at the hospital with the sick, keeping vigil, and apologizing for even the most trivial matters to ensure they are not "visited" after death. (Kowarska, 2005; Majda, et al., 2009; Ficowski, 2013; Nowicka, 2014; European Commission, 2020).

Care and attention to the patient require meeting the cultural needs and beliefs of individuals and families. Religion often provides spiritual guidance and emphasizes healthcare. A person's culture and religion can significantly influence their views on healthcare and healthcare professionals. Medical and health science students, as future professionals, must understand the origins and beliefs of these patients to ensure culturally sensitive healthcare in the future. (Swihart, et al., 2023).

References

Almansour, H. A., Chaar, B., & Saini, B. (2017). Fasting, diabetes, and optimizing health outcomes for Ramadan observers: A literature review. *Diabetes Therapy*, 8(2), 227-249. https://doi.org/10.1007/s13300-017-0233-z

Arora, A., & Kumar, A. (2024). Liver and liver disease in Hinduism. *Clinical Liver Disease*, 23(1), e0245. https://doi.org/10.1097/CLD.0000000000000245

Bauer-Wu, S., Lhundup, T., Tidwell, T., Lhadon, T., Ozawa-de Silva, C., Dolma, J., Dorjee, P., Rapten Nesher, D., Sangmo, R., & Yeshi, T. (2014). Tibetan medicine for cancer: An overview and review of case studies. *Integrative Cancer Therapies*, 13(6), 502-512. https://doi.org/10.1177/1534735414549624

de Brito Sena, M. A., Damiano, R. F., Lucchetti, G., & Peres, M. F. P. (2021). Defining spirituality in healthcare: A systematic review and conceptual framework. *Frontiers in Psychology*, 12, 756080. https://doi.org/10.3389/fpsyg.2021.756080

Callender, K. A. (2015). Understanding antigay bias from a cognitive-affective-behavioral perspective. *Journal of Homosexuality*, 62(6), 782-803. https://doi.org/10.1080/00918369.2014.998965

Chakraborty, R., El-Jawahri, A. R., Litzow, M. R., Syrjala, K. L., Parnes, A. D., & Hashmi, S. K. (2017). A systematic review of religious beliefs about major end-of-life issues in the five major world religions. *Palliative & Supportive Care*, 15(5), 609-622. https://doi.org/10.1017/S1478951516001061

Center for the Study of Global Christianity. (2022). *Center for the Study of Global Christianity*. Gordon-Conwell Theological Seminary. https://www.gordonconwell.edu/center-for-global-christianity/

Cummins, P. J., & Nicoli, F. (2018). Justice and respect for autonomy: Jehovah's witnesses and kidney transplant. *Journal of Clinical Ethics*, 29(4), 305-312. PMID: 30605440

Donum Vitae. (1987). *John Paul II*. https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19870222_respect-for-human-life_sp.html

Duckitt, J. (2014). *Prejudice: Its social psychology. Journal of Multilingual and Multicultural Development*, 35. https://www.researchgate.net/publication/263497849_Prejudice_its_social_psychology/citation/download

European Commission. (2020). *Roma equality, inclusion, and participation in the EU*. https://commission.europa.eu/strategy-and-policy/policies/justice-and-fundamentalrights/combatting-discrimination/roma-eu/roma-equality-inclusion-and-participation-eu_en

Evangelium Vitae. (1995, March 25). *John Paul II*. https://www.vatican.va/content/john-paulii/es/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html

Ficowski, J. (2013). *Cyganie na polskich drogach*. Wyd. Nisza.

Fouka, G., Plakas, S., Taket, A., Boudioni, M., & Dandoulakis, M. (2012). Health-related religious rituals of the Greek Orthodox Church: Their uptake and meanings. *Journal of Nursing Management*, 20(8), 1058-1068. https://doi.org/10.1111/jonm.12024

Gabbay, E., McCarthy, M. W., & Fins, J. J. (2017). The care of the ultra-Orthodox Jewish patient. *Journal of Religion and Health*, 56(2), 545-560. https://doi.org/10.1007/s10943-017-0356-6

Giger, J. N., & Haddad, L. G. (2021). *Transcultural nursing: Assessment and intervention* (8th ed.). Elsevier.

Griswold, W. (2012). *Cultures and societies in a changing world*. SAGE Publications.

Groh, A. (2019). *Theories of culture*. Routledge.

Gwynn, D. M. (2007). From iconoclasm to Arianism: The construction of Christian tradition in the iconoclast controversy. *Greek, Roman, and Byzantine Studies*, 47, 225-251. https://grbs.library.duke.edu/index.php/grbs/article/view/651/731

Iglesias, A., Gómez i Segalà, J., & Twose, J. (2023). *Diversidad religiosa y la donación de órganos y tejidos*. Generalitat de Catalunya. Organización Catalana de Trasplantes. https://scientiasalut.gencat.cat/bitstream/handle/11351/9636/guia_sobre_%20diversitat_%20religiosa%20_donaci%C3%B3_organs_teixits_2023_cas.pdf?sequence=5&isAllowed=y

Khoo, T. (2023). Buddhism. In M. K. Calhoun (Ed.), *Cancer treatment research* (Vol. 187, pp. 153-159). Springer. https://doi.org/10.1007/978-3-031-29923-0_11

Koh, H. K., Piotrowski, J. J., Kumanyika, S., & Fielding, J. E. (2011). *Healthy People*: A 2020 vision for the social determinants approach. Health Education & Behavior, 38(6), 551-557. https://doi.org/10.1177/1090198111428646

Kowarska, J. (2005). *Polska Roma. Tradycja i nowoczesność*. Warszawa.

Kozubik, M., van Dijk, J. P., & Filakovska Bobakova, D. (2019). Aspects of illness and death among Roma: Have they changed after more than two hundred years? *International Journal of Environmental Research and Public Health*, 16(23), 4796. https://doi.org/10.3390/ijerph16234796

Krasnowolski, A. (2022). *Cyganie/Romowie w Polsce i w Europie: Wybrane problemy historii i współczesności*. Kancelaria Senatu. Biuro Analiz i Dokumentacji. https://www.senat.gov.pl/gfx/senat/pl/senatopracowania/5/plik/ot-603.pdf

Leong, M., Olnick, S., Akmal, T., Copenhaver, A., & Razzak, R. (2016). How Islam influences end-oflife care: Education for palliative care clinicians. *Journal of Pain and Symptom Management*, 52(6), 771-774.e3. https://doi.org/10.1016/j.jpainsymman.2016.05.034

Majda, A., Ogórek-Tęcza, B., & Zalewska-Puchała, J. (2009). *Pielęgniarstwo transkulturowe*. PZWL.

Nowicka, E. (2014). Kontrowersja religijna i kontrowersja kulturowa. Romowie zielonoświątkowcy w Szaflarach. *Studia Humanistyczne AGH*, 13(3), 165-183. https://bazhum.muzhp.pl/media/texts/studiahumanistyczne-agh/2014-tom-13-numer-3/studia_humanistyczne_agh-r2014-t13-n3-s165-183.pdf

Office of Disease Prevention and Health Promotion. (ODPHP). (2020). *Social determinants of health: Healthy People 2030*. https://odphp.health.gov/healthypeople/priority-areas/social-determinantshealth

Ordys, D., & Eszyk, J. (2007). Rola pielęgniarki w opiece nad pacjentami umierającymi różnych wyznań. In E. Krajewska-Kulak, W. Nyklewicz, J. Lewko, & C. Łukaszuk (Eds.), *W drodze do brzegu życia* (Vol. 2, pp. 87-94). Wydawnictwo AM w Białymstoku. https://www.umb.edu.pl/photo/pliki/Dziekanat-WNOZ/monografie/tom_2%281%29.pdf

Pawlak, Z. (2002). *Katolicyzm A-Z*. Księgarnia Św. Wojciecha.

Pew Research Center. (2018). *Being Christian in Western Europe*. https://www.pewresearch.org/religion/2018/05/29/being-christian-in-western-europe/

Poveda, A., Ibáñez, M. E., & Rebato, E. (2014). *Obesity and body size perceptions in a Spanish Roma population*. Annals of Human Biology. https://www.researchgate.net/publication/260377289_Obesity_and_body_size_perceptions_in_a_Spanish_Roma_population

Pruszynski, J., & Grabowska-Grzyb, A. (2007). Potrzeby i oczekiwania prawosławnych chrześcijan w czasie choroby i schyłkowego okresu życia. *Gerontologia Polska*, 15(4), 128-136.

Real Academia Española. (n.d.). *Cultura*. In Diccionario de la lengua española. https://dle.rae.es/cultura?m=form

Real Academia Española. (n.d.). *Sociología*. In Diccionario de la lengua española. Retrieved January 15, 2025, from https://dle.rae.es/sociolog%C3%ADa?m=form

Real Academia Española. (n.d.). *Religión*. In Diccionario de la lengua española. Retrieved January 15, 2025, from https://dle.rae.es/religi%C3%B3n?m=form

Ríos, A., López-Gómez, S., Belmonte, J., Balaguer, A., Gutiérrez, P. R., Ruiz-Merino, G., Ayala-García, M. A., Ramírez, P., & López-Navas, A. I. (2023). The Roma population's fear of donating their own organs for transplantation. *Cirugía Española (English Edition)*, 101(5), 350-358. https://doi.org/10.1016/j.cireng.2022.06.043

Samaritanus Bonus. (2020). *Congregation for the Doctrine of the Faith*. https://press.vatican.va/content/salastampa/es/bollettino/pubblico/2020/09/22/carta.html

Swihart, D. L., Yarrarapu, S. N. S., & Martin, R. L. (2025, January). *Cultural religious competence in clinical practice*. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK493216/

Final Reflection: Religious and Cultural Practices and the EMPOWER Model

by Małgorzata Szkup

This chapter offers a broad overview of **religious, spiritual, and cultural practices** related to health, highlighting their influence on patient decisions and the care process. This diversity of perspectives aligns closely with the values of the EMPOWER model, particularly in the areas of Multiculturalism, Professionalism, Effectiveness, and Education Resources.

The author emphasizes that competent care requires **openness, respectful dialogue**, and **avoidance of stereotypes**, which reflects the core EMPOWER principle of cultural humility. The chapter shows how religious beliefs can shape attitudes toward organ donation, transfusions, abortion, or end-oflife care—demonstrating that delivering effective healthcare demands **flexibility and respect for patient values**.

The rich examples of practices from various religions and ethnic groups serve as a valuable **educational resource**, aligning with EMPOWER's emphasis on **experience-based cultural learning**. The chapter also underscores the need to develop strong **communication** and **ethical skills** when working with patients from different belief systems—central to EMPOWER's vision of **reflective professionalism**.

In summary, this chapter demonstrates that **understanding cultural and religious diversity is not about memorizing facts, but about adopting an attitude of respect and ongoing learning**—a foundation for effective, empathetic, and equitable care, fully consistent with the spirit of the EMPOWER model.

Multi Culti Med

Chapter 13

Multiculturalism in Medicine – Ethical Issues

MAGDALENA KUCZYŃSKA
Pomeranian Medical University in Szczecin (Poland)

> **All Real Living is Meeting.**
>
> — Martin Buber

13.1. Introduction

The term "culture" can be applied to both social groups and the individuals who make them up. The culture of a society consists of, among other things: language, collective systems of beliefs, convictions, views, values (including moral values), norms, rituals, as well as knowledge, art, and law (Spencer-Oatey, 2012; Gajda, 2003). A person who is a member of a social group co-creates collective culture while simultaneously drawing from it. Moreover, they bring their individual cultural resources, such as race, gender, age, sexual orientation, personal value hierarchy, and worldview, into it. This understanding of culture creates a space for the development of two polarized social structures: monoculture and multiculturalism. In the content presented below, the reader's attention is directed towards multiculturalism in a moral context.

Every encounter with another person is a confrontation with their distinct culture in its multifaceted understanding.

The process of engaging with the material presented in the chapter can take two forms: 1. A non-reflective, and therefore less impactful, engagement with the theoretical material, or 2. An active assimilation of the material with a deep sense of its practical dimension, which is strongly recommended. The learning process is more effective when the student is convinced that the knowledge being acquired will be useful in practice. So where can we find multicultural interpersonal relationships in the field of medicine?

Students who are the intended readers of this book live in various parts of the world. Among them are countries with complex social structures that host numerous cultures. These readers may find it easier to place the content of this chapter within their daily lives, which are saturated with encounters with multiculturalism, in a narrower sense (let's call it narrow for the purposes of this chapter), referring primarily to nationality, religion, origin, and sexual orientation. In a somewhat different situation, it might seem at first glance, are readers living in countries that are not particularly common destinations for immigration and, therefore, are characterized by relatively homogeneous manifestations of social culture. However, multiculturalism definitely extends beyond this narrow understanding. As mentioned in the beginning of the chapter, each person possesses a set of cultural components that are unique to them. Some of them are permanent, like gender, while others are constantly changing, like age. This is the first basic piece of knowledge that the reader should take away from this chapter: **we should not look for multiculturalism only in its narrow sense (for example, a patient is a tourist from a culturally different part of the world). Every encounter with another person is an encounter with their distinct culture in a multifaceted understanding**.

Moving to the core of the chapter, two essential questions must be posed:

- Which values and moral norms contribute to the formation of a prosocial attitude towards cultural diversity?
- Why can implementing the proposed values and moral norms help optimize functioning in the medical environment (with particular focus on patient care) in the context of multiculturalism, while respecting one's own cultural distinctiveness?

Aims

Through this chapter students will enhance their attitudes, knowledge and skills and will be able:

- To characterize the terminology used in the text in its general meaning.
- To contextualize the aforementioned terminology within the framework of multiculturalism in medicine and to justify its relevance to the discussed topic.
- To present proposals for individual and group exercises aimed at supporting the development of an open attitude towards multiculturalism in medicine while respecting one's own value system.

The author of the chapter is aware that the values and moral principles that seem appropriate for the creation of a multicultural community represent an exceptionally broad spectrum. The material presented neither exhausts this spectrum nor claims to do so. Furthermore, the terms used in the text, mostly from the fields of philosophy and ethics, and their placement in the multicultural medical environment, also remain open-ended and unfinished. The author's intent and scientific-educational desire are to initiate the reader's own reflection on the moral dimension of encounters with others and their cultural richness, regardless of their assigned social role (student, patient, and their close ones, member of the therapeutic team). Ultimately, these encounters will take place in the individual "I - you" space. The reference to the philosophy of dialogue is used consciously and purposefully (Buber, 1971). Undoubtedly, the message of the chapter is also to motivate the reader to engage in a broader discussion on the emerging moral dilemmas at the intersection of many cultures in the field of medicine. We are convinced that, to some extent, the exercises proposed in the final part of the chapter will contribute to this.

Three components of moral attitude:
- *Cognitive – consists of thoughts, beliefs, and knowledge about the object of the attitude.*
- *Affective – refers to the emotions felt towards the object of the attitude.*
- *Behavioral – refers to the behaviors presented towards the object of the attitude.*

Learning Outcomes

By the end of this chapter, readers will be able to:

- Characterize the terms discussed in the chapter: human dignity and tolerance.
- Demonstrate the application of the terminology presented in point 1 in the context of multiculturalism in medicine.
- Show awareness of morally unacceptable attitudes in the context of multiculturalism in medicine.
- Demonstrate internal coherence between the three components of attitude: cognitive, affective, and behavioral, in relation to multicultural relationships in medicine.

Relevant Definitions and Terms

Introducing the topic of ethics in multiculturalism requires defining the necessary terminology in its general sense (without references to multiculturalism in medicine). To begin, I will address some fundamental concepts. This subchapter will focus on the notions of human dignity and tolerance.

Before the reader delves into the terminology rooted primarily in philosophy and ethics, it is important to note a significant limitation applied in the text. The attempt to define the concepts below had to be done succinctly enough so that the reader would not get lost in the maze of philosophical debates. Instead, the goal was for the reader to master the terms in such a way that they form a clear framework for the practical part, which will primarily involve any relationship in the medical environment. This necessitated an authoritative choice of certain philosophical trends and the definitions developed within them. The individual worldview preferences of the author played no role in this selection. The only criterion was the appropriateness of the presented definitions for the leading topic, which is multiculturalism in medicine.

Human dignity – The term "dignity" (Latin "dignitas") was introduced by Cicero (Shershow, 2013). In its original meaning, it referred to ethical and aesthetic values such as beauty and attractiveness. Being a person of dignity meant someone who exhibited beauty through their demeanor. Over time, the term "dignity" began to be used, for example, in the Polish language, as a synonym for the word "surname" ("What is your dignity?" means "What is your surname?"). It acquires yet another meaning in statements like "I have a sense of dignity," referring to our internal respect for ourselves.

From the perspective of the book's main theme, we placed particular emphasis on an internal human quality: dignity.

- What is its nature (what are its properties and characteristics)?
- Does every person possess it, and if so, what is its source?
- And perhaps the most compelling question: what does it mean in practical terms for your dignity, my dignity, and everyone's? Does this concept impose any mutual obligations on us?

Each of these short questions has been the subject of countless reflections in philosophy, religion, law, psychology, and sociology (Charter of Fundamental Rights of the European Union, 2000; Dignity, 2023). Some of them are positioned at two opposite extremes. Legal concepts can significantly differ regarding the recognition of specific attributes (characteristics) of human dignity. What is certain is that the terms "human dignity," "dignity of the human being," or, following the personalist philosophy, "dignity of the human person" (in philosophy and ethics, most words, seemingly synonymous, carry specific, distinct meanings. Therefore, their selection must be intentional) are simultaneously very general, highly complex, and even controversial. I will therefore focus on the most important content from the perspective of the topic. Due to the diversity of philosophical-ethical

views and the need for clarity in the text, the following interpretation of "human dignity" is largely based on the personalist school mentioned above.

Characteristics of "human dignity" – inalienability, inviolability, non-gradability, non-transference (Środa, 2010). This means that a person is born with the dignity that belongs to them, which they do not need to earn, and neither they nor anyone else can take it away. It is not gradable – one cannot have more or less human dignity.

> *"Human dignity is inviolable. It must be respected and protected".*
>
> *– Charter of Fundamental Rights of the European Union, 2000*

Does every person have dignity? What is its source? The answer to the first question is simple. Yes, being human is synonymous with being endowed with dignity, understood in the sense discussed here. The second issue has a wide variety of arguments (we will also consider ideas that go beyond personalism). Here are some of them:

- Human dignity stems from the attribute of rationality and free will. This interpretation was supported by, among others, Immanuel Kant (Düwell, et al., 2015).
- A person is created in the image of God, and this constitutes the source of their dignity. This concept, as one might expect, is propagated by those who practice philosophy within a religious framework.
- The human capacity for reflection and moral choices (Środa, 2010).
- The ability to work and, thus, shape the surrounding reality in a purposeful and conscious way makes a person worthy (Środa, 2010).

Human dignity – from theory to practice: Accepting the fact that we possess inborn and inalienable dignity leads to reflection: How does this philosophical, abstract concept translate into social relationships and the norms that shape them?

One of the most important consequences is the connection between the awareness of human dignity and the codification of rights inherent to it, such as the Universal Declaration of Human Rights (United Nations, 1948), or patient rights present in many countries. Unfortunately, the history of humanity reveals numerous examples of violations of human dignity every day. International conflicts, internal disputes, and family quarrels are behaviors that people in every corner of the world must confront. Therefore, law should provide clear guidelines for protecting the fundamental value of human dignity. But does law, even if perfectly constructed, constitute a sufficient condition for the development of pro-social attitudes based on respect for human dignity? While it is an essential regulator of social order, it is not enough by itself. This insufficiency of law may be particularly evident in direct relationships with another person, especially when one party is in an unfavorable position relative to the other. For example, when their freedom is infringed in terms of law (prisoners), health status (patients in intensive care units), or political

conditions (immigrants), to a greater or lesser extent. What additional condition is, therefore, necessary in building the attitudes mentioned? At this point, I will refer to Lawrence Kohlberg's theory of moral development (human dignity is a fundamental moral value). In his years of research, he observed different stages of a person's maturation in response to the world of values (for those interested in the entire topic, I refer them to the website https://courses.lumenlearning.com/suny-lifespandevelopment/chapter/kohlbergsstages-of-moral-development/, where the issue is described in greater detail) (Kohlberg&Kramer, 1969; Zhang&Zhao, 2017). For the topic of this chapter, the following conclusions from Kohlberg are important: at a certain stage (it must be noted that it is quite an advanced stage in an individual's development), a person realizes moral values as long as they are justified by the applicable law. Returning to the main issue – individuals whose moral development is at the "law and order" level will respect human dignity, provided it is regulated by legal order. However, life cannot be "contained within the confines of law." Even the most precise legislations do not resolve all social situations. This is where the second key conclusion from Kohlberg's research comes into play: the highest stage of moral development is respecting moral values because of the inherent good present in them. Yes, this may sound overly philosophical. Therefore, an example of how Kohlberg's theory can be applied in practice is presented in the box below.

Situation: A senior customer enters the store. She hands her entire wallet to the cashier, asking her to choose the money for the purchases. The saleswoman, taking advantage of the senior's trust, has the opportunity to pocket even a small amount. She does not do so. We are interested in answering the following question:

What is her motivation for the morally correct action? (refraining from theft)

- **Answer 1:** The saleswoman refrains from stealing because she knows that the law prohibits it, and violating the law could result in serious consequences (she frames her moral action within legal constraints).
- **Answer 2:** The saleswoman refrains from stealing because she has an internal conviction that the act is morally wrong, that it causes harm to another person. According to Kohlberg, this reasoning represents the highest level of moral maturity.

Thus, the awareness of another person's dignity can be considered an important regulator of interpersonal relationships. The question remains whether being "equipped" with dignity simply because of belonging to the human species is enough to expect respect. Should this trait (which, let us note, we have no influence over, assuming the concept of its inborn nature) not be complemented by the necessity of behaving decently? The view that this is indeed the case seems reasonable. And here we arrive at an important observation worth internalizing: if I acknowledge that I possess dignity, I should act morally correctly, which, among other things, means respecting the dignity of others (as well as my own). Isn't this

the ideal way to establish open relationships in a multicultural dimension? We will return to this idea in the next subchapter.

Tolerance – one of the most demanding moral ideas. Difficult to implement, yet fundamental to ethics in a multicultural world. Understanding the criteria of tolerance and its limitations would help build a world free of tensions in interpersonal and intercultural relationships. Let us briefly discuss the mentioned criteria. The foundation of tolerance lies in certain behaviors worth remembering. Here they are (Środa, 2010):

1. There exists a factor, attitude, or behavior in our surrounding environment (represented, of course, by a specific person or people) that causes me opposition, and it may even be in conflict with my hierarchy of values.
2. I have the possibility to act against this phenomenon. I may try to change the existing state of affairs through force, persuasion, or spreading false information (e.g., causing the social isolation of the person holding the views mentioned in point 1).
3. I refrain from acting to the detriment of the phenomenon mentioned in point 2.

This understanding of tolerance is called "negative tolerance" in ethics – negative because it expresses a lack, in this context, the lack of our destructive reaction to someone else's attitude or views. It is the minimum moral obligation we must adhere to. At the same time, the idea of tolerance is a claim-based idea: I show tolerance towards you, but you show tolerance towards me. There is also the concept of "positive tolerance." This attitude takes a significant step forward by adding the last criterion, which is best captured by Voltaire's statement, **"I disapprove of what you say, but I will defend to the death your right to say it"**. Positive tolerance is not just refraining from acting against the phenomenon mentioned in point 1 (criteria of tolerance). It involves actively supporting it with respect for the

equality of all people. This occurs within the boundaries of tolerance, which will be discussed shortly.

The literature on the topic points to several sources justifying the existence of tolerance, but their discussion lies beyond the scope of this chapter. Undoubtedly, one of the most important values upon which tolerance is based is human dignity and the equality of all people derived from it, understood in a moral context.

Tolerance has its limits; otherwise, it would require openness to antisocial attitudes. We strongly oppose this idea. It must be clearly stated that tolerance should only be applied to attitudes, views, and behaviors that fall within the legal, moral, and political boundaries (a view put forward by the philosopher J.S. Mill). It is also important to emphasize that tolerance, as a moral stance, is not the same as acceptance. We may accept differing views, even sympathize with them, but we are not required to. As mentioned earlier, tolerance constitutes the moral minimum in the interest of a multicultural world.

13.2. Human Dignity as the Supreme Value in Multicultural Relations in Medicine

In section 13.1. we entered the world of two philosophical and ethical concepts in their general meaning. Now, we will try to place them within the context of multiculturalism in medicine, in relation to practices concerning patients, their families, and in employee relations. The goal of sections 1.5 and 1.6 is to search for an answer to the question: Can respect for human dignity and openness to the phenomenon of tolerance support prosocial attitudes in a multicultural medical environment?

Patient dignity is the dignity of a person filled with fear for their life and health. It is the dignity of those close to them, worried about entrusting their loved one to the hands of nurses, midwives, doctors, physiotherapists, and paramedics. Finally, it is the dignity of the people with whom we share the struggles and joys of long shifts. Every participant in this relationship brings their cultural background to it. This is nothing unusual, as everyday relationships we experience in public spaces are also characterized by this. So, what makes the medical field so special that it is worth, as the authors of this handbook have done, focusing on the meaning of human dignity as a fundamental value in this specific area of medicine within the context of cultural diversity?

The view on which we based section 13.1. assumes that dignity is considered a characteristic inherent to each of us. It does not depend on race, gender, sexual orientation, financial status, or age. Moreover, such an understanding of innate and inalienable dignity requires us to recognize it even in people who have committed morally unjust acts. However, it is important to emphasize the word "in people," not in their actions, which deserve appropriate condemnation and punishment according to their wrongdoing. Let's return now to the sentence from the introduction to this chapter. Every encounter with another person is an encounter with their distinct culture in a multifaceted understanding. Thus, when I engage with you in all your cultural richness, I am also confronted with both your and

my human dignity. I – a representative of the medical world, and you – a patient, a family member, a loved one. You – my colleague at work.

So, what is the most important outcome of this meeting? It is the feeling of **human equality** within the basic value of dignity. If we accept this conclusion with genuine and deep understanding, we will realize that from the moment we meet another person, we begin to build our relationship on one strong foundation. The various factors arising from cultural diversity only enrich the relationships we create. Let's try to visualize this thought. We have a square on which we can place various buildings. This square is a metaphor for our professional life. The buildings represent every person who appears in this life. We can place each of them only on their designated foundation with the surrounding piece of sidewalk. However, there is a risk that moving from one building to another, we will encounter gaps and unevenness that have formed between them. They are, after all, very diverse just like our patients and colleagues, some are calm, others more prone to intense emotions, some are healthier and happier, others are dying and depressed. Some are young and full of life, while others are seniors, often terrified by the prospect of illness and frailty. There are also those who can communicate easily in our native language and others with whom communication will be very difficult). Such a constructed square would, over time, become a collection of random buildings, creating a hazard for the passerby moving between them (that is, us).

However, if we begin our work with the concept of unity and human equality, based on the foundation of human dignity, we will start building this metaphorical square by placing a single, strong foundation. The multiculturalism of every person we meet in our professional life will make our "square" colorful, beautiful, and rich. Viewing another person from the perspective of their dignity offers the chance to build morally correct relationships from the very foundation, thus promoting good quality of life for patients, their dignified dying, or, in relation to colleagues, a favorable atmosphere in the workplace.

> *Every encounter with another person is a confrontation with their distinct culture in its multifaceted understanding. Every individual is characterized by innate and inalienable human dignity. Therefore, every encounter with another person is an engagement with the human dignity that belongs to them.*

We also mentioned earlier that the relationship with another person becomes a starting point for reflection on the dignity that I myself am endowed with. It obliges me to respect my own rights and myself. And although from the first day of studies we embrace the idea of "Salus aegroti suprema lex esto" (The welfare of the patient should be the highest law), let us make the patient the center of our care while simultaneously and proportionally expecting respect for ourselves and the culture we bring. Our age, gender, nationality, and other cultural variables demand the same protection and respect from the patient, family, and colleagues as they expect from us.

13.3. Tolerance and Multiculturalism in Medicine

We already know from section 13.1. what the term "tolerance" means. This attitude plays a key role in multicultural medicine. When facing people who bring with them their world of culture, whether they are patients experiencing illness or we are concerned with optimal therapy, every even fleeting interaction is an opportunity to demonstrate a tolerant attitude. The more culturally diverse the groups we encounter in our work, the more difficult this becomes. It requires us to restrain from expressing opposition to differences.

Let's provide an example:

We have started working in a country where the customs associated with saying goodbye to the deceased differ greatly from those we grew up with. The behavior of the deceased's relatives may seem strange or irritating to us. It may also disrupt our established work schedule. At the same time, we know that the rituals performed by the family at the bedside of the deceased stem from the family's long-standing cultural tradition. We also know that the hospital (understanding the idea of tolerance) fully allows these rituals. What attitude will we take? Will we, with a glance or gesture, show impatience, dislike, intolerance? Or, even if we continue to feel confused and angry, will we refrain from even the smallest gestures of opposition? Or perhaps we will go a step further, embracing positive tolerance: creating an environment that actively supports the family?

The dignity of patients, their world, the dignity of our colleagues, and our own are the backdrop for tolerance that harmonizes multicultural relationships, even in medicine.

One of the most frequently cited examples from medicine, which allows medical personnel to demonstrate a tolerant attitude, is the refusal of a blood transfusion by Jehovah's Witnesses. In the practical section of the chapter, there is an exercise prepared for the reader on this topic.

13.4. Three Components of Moral Attitude in Relation to Multiculturalism in Medicine

One of the objectives of this chapter is to foster an open attitude towards multiculturalism in medicine, while simultaneously respecting one's own world of values. Three components of moral attitude have been identified: cognitive (thoughts, beliefs, and knowledge about the attitude object), affective (a set of emotions experienced towards the attitude object), and behavioral (behaviors exhibited towards the attitude object) (Sawicki, 2024). Let's elaborate on this thought.

Earlier, we discussed fundamental values such as dignity and tolerance. These have been treated as the foundation for building good relationships with others. However, simply respecting dignity, which is expressed through tolerance, does not equip us with sufficient competencies to develop a prosocial moral attitude in the context of multiculturalism in medicine. Why is this belief held?

The answer lies in the fact that working at the intersection of two vast and multifaceted areas—multiculturalism and medicine—poses a tremendous challenge. The diversity of configurations between them is practically infinite. Therapy directed at the patient (the term "therapy" refers to all possible actions towards the patient by members of any medical group) and considered in the context of respect for multiculturalism absolutely requires, on the one hand, medical knowledge, and, **on the other, an understanding of the customs, practices, and norms regulating the culture of the person entrusted to our care**. No one belongs solely to one cultural identity, such as gender. We are subject to intersectionality, identifying simultaneously with many characteristics, as discussed in the introductory part of the chapter. For instance, a young woman giving birth in her home country, among people who know and share her cultural norms, will have different reactions compared to a woman giving birth among medical staff with different cultural patterns, who is also in a non-heteronormative partnership. A single mother giving birth will be in yet another position. To provide comprehensive care to a patient, which necessarily includes our moral dignity, it is essential to constantly work on building the cognitive component. While recognizing dignity in another person is the starting point for forming this attitude, continuously gaining knowledge about them enables us to cultivate appropriate emotions towards them (the affective component).

The situations we encounter in medicine are, not coincidentally, the basis for numerous popular television shows set in hospital settings, such as ER, Grey's Anatomy, or Dr. House. The everyday dramas of human life, unexpected twists, joy interspersed with sadness, hope and its end, the exhaustion of nurses, midwives, doctors, and paramedics —a conglomerate of emotions at the highest level of feeling. It is so easy to lose empathy within this. Now, let's layer on these "fast lanes" the additional variables arising from our multiculturalism. Merely respecting the dignity of another person will not suffice. Working based on emotions without a foundation of knowledge may be detrimental to all parties involved. By understanding the cultural sources of human behavior, it is much easier to strengthen positive emotions in ourselves and suppress negative ones. Understanding why our patient, their loved ones, and our colleagues behave in a certain way and being aware of the significance it holds for the culture with which they identify will serve as guideposts in the tangled maze of paths. Both the cognitive and affective components will form the basis for the main manifestation of our work: behavior expressed through action (the behavioral component). Equipped with **knowledge**, I understand others (especially behaviors that are different from mine, difficult to accept)—understanding means opening myself up to **positive emotions** towards others. Equipped with knowledge and fueled by good emotions, I proceed to **act**. The ethics of multiculturalism in medicine condensed in a nutshell, as it often is with medications. After all, the moral attitude with which we enter the world of medicine should be like the best medicine, not a poison made from a mix of ignorance, harmful emotions, and intolerance.

13.5. Conclusions

We have collectively gone through the theory, which provides only modest foundations for the ethics of multiculturalism in medicine. As mentioned in the introduction, this topic has certainly not been fully explored. We would venture to say that it has only been very briefly signaled. The contents of the chapter were intended to serve the Socratic role of a gadfly, provoking thought... Perhaps they will even evoke opposition or rebellion in some readers. If that happens, it is good, because the most important thing from the perspective of our culturally rich patients, their loved ones, our colleagues, and ourselves is to engage in reflection on the ethical foundations of human and intercultural relationships.

It is impossible, in conclusion, not to mention the existence of difficult, morally conflicting situations, generated at the intersection of different cultural expressions. These situations cannot be avoided. It is also impossible to provide a ready-made solution that would be beneficial to all parties involved in the conflict. Sometimes, it is not even feasible. Surely, many examples of seemingly "hopeless" situations, characteristic of one's country, workplace, or culture, come to mind for the reader. However, in order not to leave the reader in a complete void regarding proposed solutions to moral problems within the context of multiculturalism in medicine, we suggest always grounding the alternatives discussed in the values mentioned in the concluding chapter: **human dignity, tolerance, moral maturity at a high level, and a solid dose of knowledge**.

References

Buber, M. (1971). *I and thou*. Scribner Macmillan, Scribner Book Co.

Düwell, M., Braarvig, J., Brownsword, R., & Mieth, D. (Eds.). (2015). *The Cambridge Handbook of Human Dignity: Interdisciplinary Perspectives*. Cambridge University Press.

European Union. (2000). *Charter of Fundamental Rights of the European Union*, art. 1 (Human dignity). Official Journal of the European Communities, C 364/1. https://eur-lex.europa.eu/legalcontent/EN/TXT/?uri=celex%3A12012P%2FTXT

Gajda, J. (2003). *Antropologia kulturowa. cz. 1: Wprowadzenie do wiedzy o kulturze*. Adam Marszałek.

Kohlberg, L., & Kramer, R. (1969). Continuities and discontinuities in childhood and adult moral development. *Human Development*, 12(2), 93–120. https://doi.org/10.1159/000270857

Sawicki, K. (2024). Postawy moralne młodzieży. In Ł. Szwejka (Ed.), *Postawy i styl życia młodzieży* (p. 69). Instytut Badań Edukacyjnych.

Schroeder, D. (2023). Dignity. In E. N. Zalta & U. Nodelman (Eds.), *The Stanford encyclopedia of philosophy* (Fall 2023 Edition). Metaphysics Research Lab, Stanford University. https://plato.stanford.edu/entries/dignity/

Shershow, S. C. (2013). *Deconstructing dignity: A critique of the right-to-die debate*. University of Chicago Press. ISBN: 9780226088266.

Spencer-Oatey, H. (2012). *What is culture? A compilation of quotations*. http://www2.warwick.ac.uk/fac/soc/al/globalpad/interculturalskills/ [17.03.2025].

Środa, M. (2010). *Etyka dla myślących*. Czarna owca.

Zhang, Q., & Zhao, H. (2017). An analytical overview of Kohlberg's theory of moral development in college moral education in mainland China. *Open Journal of Social Sciences*, 5, 151-160. https://doi.org/10.4236/jss.2017.58012

Final Reflection: Ethics of Multiculturalism in Medicine and the EMPOWER Model

Małgorzata Szkup

This chapter addresses key questions about **which moral values foster an open attitude toward cultural diversity in medicine**. It places strong emphasis on the concepts of **human dignity, tolerance, and moral maturity**—all of which resonate deeply with the EMPOWER model, particularly its pillars of Multiculturalism, Professionalism, Wellness, and Education Resources.

The author highlights that every interaction in the medical setting—with a patient, a family member, or a colleague—is simultaneously an encounter with a **unique cultural identity**, and thus with that person's inherent dignity. This perspective fully supports EMPOWER's vision of **holistic, empathetic, person-centered care**. Importantly, tolerance is not framed as passive acceptance, but as an **intentional ethical restraint from harmful reactions**—a moral minimum expected from professionals working in multicultural environments.

The chapter also introduces a **model of moral attitude** based on three components: cognitive, emotional, and behavioral. This structure mirrors EMPOWER's focus on **reflective, informed**, and **compassionate action**, grounded in knowledge and guided by ethical awareness.

In summary, this chapter strongly reinforces the implementation of the EMPOWER model in practice. It demonstrates that **ethical intercultural competence** is not merely a set of skills, but a **deep, value-based stance rooted in respect, maturity, and meaningful "I–You" relationships**, in the spirit of dialogical philosophy and EMPOWER's core principles.

Multi Culti Med

Chapter 14

Human Rights

OLHA FEDORTSIV, EMILIA BURBELA, VOLODYMYR DZHYVAK

Ivan Horbachevsky Ternopil National Medical University of the Ministry of Health of Ukraine

> **All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.**
>
> — United Nations. Universal Declaration of Human Rights, 1948

14.1. Introduction

Human rights are based on the principles of dignity, equality and freedom, which are the foundation of a just and harmonious society. These principles ensure that every person, regardless of their ethnic, cultural, social or religious background, has the same rights and opportunities.The universality and indivisibility of human rights are key values that ensure equality of civil, political, economic, social and cultural rights. These principles are reflected in the Universal Declaration of Human Rights, which emphasises that all human beings are 'born free and equal in dignity and rights' (United Nations Population Fund. Human rights principles, 2005).

The idea of human rights also encompasses the importance of mutual respect and tolerance in a multicultural environment. Adherence to these values contributes to social cohesion, integration of different cultures and prevents discrimination. Human rights act as a guide for creating a society where diversity is seen as a source of strength rather than a challenge (Polnikova, 2024).

The principles and values underpinning human rights are the foundation of a just and harmonious society. They ensure that everyone, regardless of ethnic, cultural, social or religious background, has equal rights and opportunities. The universality and inalienability of human rights means that all people in the world have these rights and cannot be deprived of them. The indivisibility of human rights emphasises that all rights - civil, cultural, economic, political and social - are interrelated and of equal value. Deprivation of one right has a negative impact on the others (United Nations Population Fund. Human rights principles, 2005).

Mutual respect and tolerance are important in a multicultural society. These values promote social cohesion, integration of different cultures and prevent discrimination. Tolerance is based on the equal dignity of all people who deserve respect as rational individuals capable of creating and defining their own identity (Tadmor, Galinsky & Maddux, 2012).

Adherence to these principles contributes to the creation of a society where diversity is seen as a source of strength rather than a challenge. Recognising and respecting cultural differences fosters dialogue, cooperation and understanding between different groups, which is key to building a harmonious and just society.

Aims

Through this chapter students will enhance their attitudes, knowledge and skills and will be able:

- **Exploring human rights:** Analyze how human rights concepts influence health care practice and policy around the world, especially in relation to access to health care, discrimination, and the right to health, which will contribute to a deeper understanding of universal values and their role in creating a just society.
- **Identify human rights violations:** Students will learn to recognize the different forms of human rights violations that can occur in health systems, including systemic inequalities and abuses, and their impact on vulnerable populations, enabling them to better understand issues such as social inequality and cultural relativism.
- **Emphasize ethical responsibility:** Emphasize the ethical responsibilities of health care professionals to protect human rights and promote social justice in their practice. This includes developing strategies for advocacy in multicultural settings and increasing competence in dealing with ethical dilemmas.
- **Application of the human rights system:** Students will understand how to apply human rights frameworks and principles in a health care context to promote equitable and just health care delivery. Students will gain practical knowledge of international legal mechanisms, such as the Universal Declaration of Human Rights, and their application in real-world situations.
- **Definition of key terms:** Accurately define key human rights terms, including "right to health," "discrimination," and "health equity," to lay a solid foundation for understanding the complexity of human rights and their importance in addressing contemporary global issues such as climate change, refugees, and social inequalities.

The aim of human rights studies is to develop a deep understanding of the universal principles of dignity, equality and freedom, which are the basis of a harmonious and just society.

Learning Outcomes

By the end of this chapter, readers will be able to:

- **Understand what human rights are:** Describe the fundamental concepts of human rights as universal, inalienable, and indivisible principles safeguarding dignity, equality, and freedom for all individuals.
- **Define key terms:** Identify and explain essential terminology related to human rights, including civil, political, economic, social, and cultural rights as outlined in international legal standards.

- **Identify contemporary issues:** Recognize current challenges in the protection of human rights globally, including disparities between countries, cultural stigmas, and societal factors that impact access to rights.
- **Apply the human rights framework:** Demonstrate how to utilize the human rights framework in analyzing social justice issues and creating strategies for promoting equality and mutual respect in multicultural environments.
- **Analyze multicultural competence:** Evaluate the importance of multicultural competence in the context of human rights, including understanding diverse perspectives and addressing the tensions arising from cultural differences and discrimination.

Relevant Definitions and Terms

Human Rights: Fundamental rights and freedoms to which all individuals are entitled, regardless of nationality, gender, ethnicity, or any other status. These rights include the right to life, freedom of expression, and access to healthcare.

Right to Health: The right of individuals to attain the highest standard of physical and mental health, which encompasses access to healthcare services, a healthy environment, and the underlying determinants of health such as food and clean water.

Discrimination: Unjust or prejudicial treatment of individuals based on characteristics such as race, gender, age, or disability, which can lead to disparities in healthcare access and outcomes.

Health Equity: The principle that everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential due to social, economic, or environmental conditions.

Universal Declaration of Human Rights (UDHR): A historic document adopted by the United Nations General Assembly in 1948, outlining the fundamental human rights that should be universally protected, including specific references to rights related to health and well-being.

Informed Consent: A legal and ethical requirement in healthcare that mandates that patients must be fully informed about the risks, benefits, and alternatives of medical interventions before giving consent for treatment.

Patient Autonomy: The right of patients to make informed decisions about their own healthcare, respecting their values and preferences, and ensuring that they have control over their medical treatment.

Vulnerable Populations: Groups of individuals who are at a higher risk of experiencing barriers to healthcare, including marginalized communities, refugees, the elderly, and those with disabilities.

Cultural Competence: The ability of healthcare providers to understand, respect, and effectively interact with patients from diverse cultural backgrounds, which is essential for ensuring equitable healthcare delivery.

Social Determinants of Health: Conditions in which people are born, grow, live, work, and age that affect health outcomes, including socio-economic status, education, neighborhood environment, and access to healthcare.

Ethical Dilemmas: Situations in which healthcare professionals face conflicting obligations related to patient care, often requiring the balancing of individual rights, public health concerns, and resource allocation.

Right to Privacy: The right of individuals to keep their personal health information confidential and to have control over who accesses their medical records and health data.

Healthcare Justice: The concept that healthcare should be distributed fairly, ensuring that all individuals have access to necessary medical services and that disparities in care are addressed.

Non-Discrimination: A principle that prohibits discriminating against individuals in healthcare settings based on race, gender, disability, sexual orientation, or other protected characteristics, ensuring equal access and treatment.

Medical Ethics: A set of moral principles that govern the practice of medicine, including respect for patient autonomy, non-maleficence (doing no harm), beneficence (acting in the patient's best interest), and justice.

Right to Education: The right of individuals to receive education about their health, including information about medical conditions, treatments, and their rights within the healthcare system.

Participatory Rights: The rights of individuals and communities to actively engage in decisions that affect their health and well-being, including involvement in policymaking and the delivery of healthcare services.

Community Health: An approach to health that emphasizes the importance of understanding and addressing the health needs of specific populations or communities, taking into account their unique social and cultural contexts.

Global Health: A field of study and practice that focuses on health issues that transcend national boundaries, recognizing the interconnectedness of health systems and the need for international cooperation in promoting public health.

Human Rights-Based Approach (HRBA): A strategy for development and social change that integrates human rights principles into all aspects of planning and implementation, emphasizing empowerment, participation, and accountability.

14.2. What the Research Say

Human rights are universal, inalienable and indivisible principles that ensure the dignity, equality and freedom of every person. They are the basis for the protection of civil, political, economic, social and cultural rights. The Universal Declaration of Human Rights (1948) was the fundamental document that defined these rights as universal and binding on all states (United Nations General Assembly. Universal Declaration of Human Rights, 1948).

In a multicultural environment, human rights are a key mechanism for ensuring equality and mutual respect. They promote social cohesion and prevent discrimination on cultural, religious or ethnic grounds. According to research, the effective implementation of human rights ensures social justice and equal access to resources regardless of a person's background (Agyare, 2024).

Globally, the protection and promotion of human rights differ widely. According to data from Our World in Data, while there has been a general improvement in human rights protections over time, significant disparities persist between countries. Factors such as governance structures, cultural norms, and economic conditions contribute to these differences (Herre & Arriagada, 2016).

According to the U.S. News Best Countries rankings and Social Purpose subranking, Denmark, Sweden and other European countries are often recognized for their strong commitment to human rights. They have strong legal frameworks and institutions designed to protect individual freedoms and promote equality. Their societies emphasize transparency, inclusiveness, and social welfare, which contribute to high human rights standards (U.S. News Best Countries rankings, 2024).

In contrast, according to the World Report 2023, the human rights situation in China has become the subject of international attention. Reports have highlighted issues such as restrictions on freedom of speech, suppression of political dissent, and concerns about the treatment of ethnic minorities. The Chinese government

often prioritizes collective rights and social stability over individual freedoms, reflecting a different philosophical approach to human rights. Saudi Arabia has been criticized for its human rights practices, particularly with regard to freedom of speech, women's rights, and the use of the death penalty. The country's legal system is based on Islamic law, which affects the interpretation and implementation of human rights. Recent reforms have been aimed at improving women's rights, but significant challenges remain (Hassan, 2023).

Historically, the concept of human rights has its origins in the philosophy of natural law that developed in antiquity. In the Middle Ages, these ideas were adapted by theologians such as Thomas Aquinas, and in the Enlightenment by philosophers such as John Locke and Jean-Jacques Rousseau. They argued that human rights are inalienable and independent of the will of the state (Perelló CFA, 2014).

Education on human rights enables the acquisition of better skills in peacefully resolving conflicts, contributing to countering extremism, and promoting ideas of tolerance and respect for others. This is especially important in multicultural societies, where different views and traditions can cause tensions. Human rights education contributes to countering extremism by promoting ideas of tolerance and respect for others. Students learn how to analyse manipulative information and recognise manifestations of radicalisation in society (UNICEF,2024). In modern international law, human rights are enshrined in a number of fundamental documents that define the standards of their protection and promote their observance at the global level. In particular, the key role is played by the International Covenant on Civil and Political Rights (1966) and the International Covenant on Economic, Social and Cultural Rights (1966), adopted by the UN General Assembly as part of the development of the International Bill of Human Rights. These covenants are part of the international legal order and oblige state parties to take measures to ensure that national legislation complies with international standards. Together with the Universal Declaration of Human Rights (1948), they form the basis of modern international human rights law (Risse, Ropp & Sikkink, eds, 2013).

Human rights play a key role in ensuring the protection of individuals in diverse sociocultural contexts, promoting the principles of equality, tolerance and overcoming discrimination. In today's world, globalisation has a significant impact on intercultural interaction, creating new challenges that require effective human rights protection mechanisms. The implementation of international human rights standards contributes not only to preserving cultural identity but also to ensuring harmonious coexistence of different groups, regardless of their ethnic, religious or social background.

In the context of human rights, it is essential to include the Convention on the Rights of Persons with Disabilities (CRPD), a key international instrument that emphasizes both legal protections and social inclusion. The Convention adopts an inclusive and comprehensive definition of persons with disabilities and firmly as-

serts that all individuals, regardless of the type of disability, are entitled to the full enjoyment of human rights and fundamental freedoms. It provides clear guidance on how various categories of rights should be applied to persons with disabilities and highlights the need for reasonable accommodations to ensure these rights can be effectively exercised. Moreover, the CRPD identifies areas where rights have historically been violated and underscores the importance of strengthening legal safeguards for this marginalized group (United Nations, 2006).

In the context of globalisation, the growth of intercultural contacts can lead to conflicts caused by inequality, prejudice or competition for resources. In such circumstances, human rights become a key tool for reducing tensions, as their main goal is to create conditions for equality and mutual respect. For example, the principles enshrined in the Universal Declaration of Human Rights (1948) and other international documents state that everyone has the right to freedom of expression, equal access to education and opportunities to fulfil their potential, which promotes social inclusion (Donnelly, 2013).

References

Agyare, P. (2024). Contextualizing human rights in multicultural environments. *Research in Social Sciences and Technology*, 9(3), 210-230. https://doi.org/10.46303/ressat.2024.56

Being different is not a problem, the challenge is rejection: Ukraine on the way to tolerance. (n.d.). *Fact-news.com.ua*. Retrieved February 20, 2025, from https://fact-news.com.ua/buti-riznimi-neproblema-viklik-u-nepriynyatti-ukraina-na-shlyahu-do-tolerantnosti/

Cole, N. L. (2024). *Understanding acculturation and why it happens*. ThoughtCo. https://www.thoughtco.com/acculturation-definition-3026039

Donnelly, J. (2013). *Universal human rights in theory and practice* (3rd ed.). Cornell University Press. http://www.jstor.org/stable/10.7591/j.ctt1xx5q2

The International Covenant on Civil and Political Rights. *Council of Europe*. https://www.coe.int/en/web/compass/the-international-covenant-on-civil-and-political-rights

Perelló, C. F. A. (2014). On supernatural law: About the origins of human rights and natural law in antiquity. *Fundamina*, 20(1), 15-26. http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S1021-545X2014000100002&lng=en&tlng=en

The Persistent Power of Human Rights. (2013). *Cambridge University Press*. https://www.cambridge.org/core/books/persistent-power-of-humanrights/D26A23B19102926B4E77B1EDEA3773F1

Tadmor, C. T., Galinsky, A. D., & Maddux, W. W. (2012). Getting the most out of living abroad: Biculturalism and integrative complexity as key drivers of creative and professional success. *Journal of Personality and Social Psychology*, 103(3), 520-542. https://doi.org/10.1037/a0029360

United Nations. (1948). *Universal Declaration of Human Rights: Article 1*. https://www.un.org/en/aboutus/universal-declaration-of-human-rights

United Nations. (2006). *Convention on the Rights of Persons with Disabilities*. https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-personsdisabilities

United Nations. (1966). *International Covenant on Economic, Social and Cultural Rights*. New York: United Nations. https://www.ohchr.org/en/instruments-mechanisms/instruments/internationalcovenant-economic-social-and-cultural-rights

United Nations General Assembly. (1948). *Universal Declaration of Human Rights*. https://www.un.org/en/about-us/universal-declaration-of-human-rights

United Nations Population Fund. (n.d.). *Human rights principles*. https://www.unfpa.org/resources/human-rights-principles

United Nations Educational, Scientific and Cultural Organization (UNESCO). (n.d.). https://www.unesco.org/en

United Nations Children's Fund (UNICEF). (n.d.). *Training for teachers helps strengthen gender equality*. https://www.unicef.org/ukraine/stories/training-for-teachers-helps-strengthen-gender-equality

U.S. News & World Report. (n.d.). *Best countries rankings: Cares about human rights*. https://www.usnews.com/news/best-countries/rankings/cares-about-human-rights

World Report 2023. (2023). *Human Rights Watch*. https://www.hrw.org/world-report/2023

Refleksja końcowa: Prawa człowieka w kontekście modelu EMPOWER

Małgorzata Szkup

This chapter emphasizes the fundamental role of **human rights** as the foundation of equality, dignity, and justice in diverse societies. This perspective strongly aligns with the EMPOWER model, particularly its pillars of Multiculturalism, Wellness, Professionalism, Effectiveness, and Education Resources.

The authors show that protecting human rights—including the right to health, non-discrimination, patient autonomy, and privacy—is not only a legal obligation for healthcare systems, but also an *everyday ethical responsibility* of healthcare professionals. Acknowledging each person's dignity and right to equal treatment reflects the core of *culturally competent and socially just care*, central to the EMPOWER philosophy.

The chapter also provides practical tools for analyzing human rights violations in healthcare, thereby enhancing professionals' *reflective and advocacy competencies*. It highlights the need to protect vulnerable groups, promote community health, and build a global dialogue grounded in **mutual respect and intercultural cooperation**—goals that fully resonate with the EMPOWER model.

This chapter translates EMPOWER's values into the language of human rights and shows that putting them into practice is e*ssential for delivering ethical, effective, and equitable care in a globally connected world.*

List of authors

MAŁGORZATA SZKUP

Associate Professor, PhD, MSc, RN

is Head of the Independent Department of Social Nursing and Vice-Dean of the Faculty of Health Sciences at the Pomeranian Medical University in Szczecin, Poland. She is an esteemed academic and practitioner in the field of nursing, with nearly two decades of experience.

Her professional journey has been deeply influenced by her passion for transcultural nursing, a field she has been dedicated to for the past 15 years. Małgorzata's leadership shines through in her role as the head of the 'MultiCultiMed' project, which fosters modern multicultural education for medical and health science students. Through this initiative, she successfully established a consortium of six European universities, enhancing international collaboration in transcultural medical education across Poland, Cyprus, Slovenia, Spain, Germany, and Ukraine.

As a committed researcher, Małgorzata has authored over 100 peer-reviewed scientific articles in both national and international journals. Her advocacy for integrating transcultural nursing into healthcare education and practice remains central to her career, contributing to the development of more inclusive and culturally competent healthcare systems across Europe.

Kontakt: malgorzata.szkup@pum.edu.pl

MAŁGORZATA ZIMNY

PhD in Health Sciences, MSc

midwife, specialist in obstetric nursing, adjunct at the Pomeranian Medical University in Szczecin, Poland. For many years, she has been involved in both education and professional practice in the field of midwifery. She combines clinical experience with teaching activities, educating new generations of specialists. Her work is guided by passion, professionalism, and a commitment to high standards of care for women and families.

Author and co-author of numerous scientific publications and book chapters. Supervisor of doctoral and master's theses, as well as reviewer of master's theses.

Actively engaged in the development of knowledge in the field of women's health.

MAGDALENA STANKIEWICZ

MSc

Lecturer in the Independent Department of Community Nursing at the Pomeranian Medical University in Szczecin, Poland.

Psychologist, sociologist, and psychotherapist. Currently enrolled in postgraduate studies in clinical sexology and forensic sexological assessment at Adam Mickiewicz University in Poznań. She is in the process of writing her doctoral dissertation entitled "Gender Identity in the Light of Selected Psychosocial Factors."

Professionally engaged in both clinical and academic work at the Pomeranian Medical University in Szczecin, where she teaches medical students and works therapeutically with patients. Her scientific interests focus on broadly understood psychopathology, the psychology of gender identity, mental health, and the psychosocial aspects of human functioning under conditions of chronic stress and emotional overload.

She pays particular attention to interdisciplinary research on the psychological determinants of personality disorders, defense mechanisms, and human psychosexual development within a biopsychosocial framework.

MAGDALENA KUCZYŃSKA

PhD, MSc, RN

is affiliated with the Independent Laboratory of Long-Term Care and Palliative Medicine at the Pomeranian Medical University in Szczecin. By primary education, she is a nurse; by postgraduate education, an ethicist and bioethicist. She holds a Doctorate in Health Sciences. Her scientific interests focus on end-of-life ethics and the broadly understood sociohumanistic aspects of medicine, including its history.

In recent years, she has expanded her educational and research focus to include gerontology. She was a co-organizer of the ten-year-long Children's Medical University Project at the Pomeranian Medical University (DUM PUM), which introduced primary school children to the intricacies of medicine. Privately, she is an admirer of the works of Michelangelo Buonarroti, of Italy, and of art in its various forms. She maintains life balance through contact with animals and the practice of crocheting.

KARMEN ERJAVEC

Professor, PhD and Vice-Rector for Research

at the University of Novo Mesto, Faculty of Health Sciences, Slovenia

Dr. Karmen Erjavec is a full professor of communication studies and Vice-Rector for Research at the University of Novo mesto. Her scientific and research work focuses on health communication, business communication, and media discourse analysis.

She has authored numerous scientific articles and book chapters, especially in the fields of healthcare, gender, and media studies. Her work has been published in internationally recognised journals. She is involved in national and international research projects, such as the comparative study on long-term care services in Slovenia and neighbouring countries. She is also known for promoting interdisciplinary approaches and the practical application of scientific findings in healthcare and education.

SABINA KRSNIK

MSc in Business and Economic Sciences

is Head of the Project and International Office and a Junior Researcher at the University of Novo Mesto, Faculty of Health Sciences, Slovenia.

Her research focuses on sustainability communication, the economy in healthcare, and business economics. She is the author of numerous scientific articles and an active contributor to regional, national, and international projects aimed at promoting innovation, inclusion, and interdisciplinary collaboration.

Her work supports the strategic development of international partnerships and enhances the university's engagement in European initiatives through practical coordination and researchbased insights.

MARIA A. MARCHWACKA

Professor, PhD

Ostfalia University of Applied Sciences in Wolfsburg, Lower Saxony, Germany. As a graduate in education and a Doctor of Communication

Science, her research focuses on educational topics in healthcare. After a decade-long appointment as a professor in the Faculty of Nursing Science and Health Sciences, she is currently employed as a professor of vocational education. Her academic interests include the didactics of healthcare professions and organisational development at Ostfalia University of Applied Sciences in Wolfsburg.

In addition to this role, she supervises dissertations at Vinzenz Pallotti University in Vallendar, Rhineland-Palatinate. Her primary research areas encompass education, training, and continuing education in healthcare professions, with a particular emphasis on professionalism, digitalisation, and (intercultural) communication.

OLHA FEDORTSIV

MD, Doctor of Medical Sciences, Professor

at the Medical Faculty of Ivan Horbachevsky Ternopil National Medical University, Ministry of Health of Ukraine, Ternopil, Ukraine.

Author of more than 300 scientific papers, 2 monographs, a textbook in English, 11 manuals, 10 information sheets, 7 patents, 10 research proposals. Under her supervision, she successfully defended 10 scientific works for the degree of Candidate of Medical Sciences. She was a member of the Specialised Academic Councils for the defence of PhD theses at Lviv National and Bukovinian State Medical Universities. Currently, she is a member of the Specialised Academic Council for Doctoral Dissertations at Ternopil National Medical University. For many years, he has been the chairman of the Ternopil branch of the Association of Paediatricians of Ukraine. She is a member of the editorial board of the journals 'Achievements of Clinical and Experimental Medicine', 'Topical Issues of Paediatrics, Obstetrics and Gynaecology', the international editorial board of the journal 'Medical science pulse' (Opole), the scientific committee of the journal 'Family Medicine & Primary Care Review' (Wroclaw).

She was the coordinator of cooperation between the Medical University of Śląsk, the University of Wroclaw and Ternopil Medical University, and is currently the coordinator of cooperation between the Medical University of Bialystok and Ternopil National Medical University.

VOLODYMYR DZHYVAK

MD, PhD

specialist in surgery and paediatric surgery, Medical Faculty, Ivan Horbachevsky Ternopil National Medical University, Ministry of Health of Ukraine, Ternopil, Ukraine. Author and co-author of about 100 scientific papers, including articles in national and international journals (25 articles indexed in the Scopus database).

Every year, he actively improves his professional skills by participating in international conferences, seminars and practical trainings on modern surgical technologies (Medical Korea Academy, etc.). He is a certified reviewer, which confirms a high level of competence in conducting expert evaluation of scientific papers for leading international publications (certified Elsevier reviewer). Member of editorial boards and reviewer of international scientific journals (Future Medicine, Deka in Medicine, American Journal of Pediatrics, etc.), where he provides expert evaluation of scientific articles on medical issues. He is a supervisor of students who participate in student scientific conferences, regularly winning prizes and demonstrating a high level of training.

ELENA ROUSOU

PhD, MSc, RN

is an Assistant Professor of Community Nursing in the Department of Nursing, School of Health Sciences, at the Cyprus University of Technology. She holds a PhD in Community-Family Nursing and Public Health and has been actively engaged in various research initiatives.

Her work focuses on community and transcultural nursing, with a particular interest in genderrelated aspects within minority and disadvantaged populations. She has participated in numerous European projects, primarily dedicated to promoting culturally competent and compassionate healthcare. Since June 2023, she has served as the Vice Chair of the European Transcultural Nurses Association.

Dr Elena Rousou is the MultiCultiMed Project coordinator, on behalf of the Nursing Department at Cyprus University of Technology.

PANAGIOTA ELLINA

PhD, MSc

holds a PhD in the Investigation of Social Inequalities in Quality of Life and Health Behaviors of Limassol Residents, a Master's in Advanced Nurse Practitioner in Community, and a Bachelor's in Nursing. Passionate about public health, social equity, and transcultural community care, she actively participates in European projects to promote inclusive and impactful healthcare initiatives.

Dr. Panagiota Ellina serves as a Research Assistant for the MultiCultiMed Project on behalf of the Nursing Department at the Cyprus University of Technology.

PARASKEVI CHARITOU

PhDc, MSc, RN

holds a BSc in Nursing and an MSc in Advanced Nursing and Health care in the Community. Her research interests focus mainly on issues of dignity of older people, elderly abuse, promoting health and quality of life of older adults in the community, especially people with Alzheimer's disease and dementia.

She has actively participated in multiple Erasmus projects primarily in the areas of culturally and ethically competent care.

Mrs Paraskevi Charitou is a research assistant for the MultiCultiMed Project, on behalf of the Nursing Department at Cyprus University of Technology.

EMILIA BURBELA

PhD, MD, Associate Professor

of the Department of Pediatric Diseases and Pediatric Surgery, Horbachevsky Ternopil National Medical University, Ukraine, Author and co-author of more than 60 scientific papers, 11 of which are in the Scopus scientometric database. Her second degree is in practical psychology. Her field of interest is psychosomatic medicine, clinical psychology and multiculturalism in medicine.

MARZENA MIKŁA

PhD, MSc, RN

is an Associate Professor at the Faculty of Nursing at the University of Murcia. She is a graduate of the University of Lodz in Poland, holds a PhD from the University of Murcia with honors (Cum Laude), and has received the Extraordinary Doctorate Award from the University of Murcia.

She works as a nurse at the Reina Sofía General University Hospital in Murcia, Spain. She is a member of the Nursing Research Group E063-04 "Nursing, Women, and Care" at the University of Murcia. She is also a member of the Advanced Nursing Care Research Group (ENFERAVANZA) at the Pascual Parrilla Murcian Institute for Biomedical Research (IMIB), Murcia. Her research interests include organ donation and transplantation, clinical nursing, multicultural nursing, and human resource management in nursing. She holds a trademark registration with the Spanish Patent and Trademark Office (No. 4,186,783). She is the author of several scientific articles.

PALOMA MORAL DE CALATRAVA

PhD, BSc

is a Profesora Titular and a member of the Department of Nursing at the University of Murcia. She holds a BSc in Medieval History (1992), a BSc in Nursing (1995), and a PhD in Medieval History (2003). Her research focuses on medieval female health and practices, as well as medieval sex and sexualities. She is the author of 40 scientific papers.

She has served as a Visiting Professor in various Spanish master's programs in nursing and was a Visiting Researcher at the University of Leeds in 2021. She held the position of School Registrar of the School of Nursing (1999–2003), Registrar of the Department of Nursing (2013–2015 and 2017F–2020), and Director of the Department of Nursing (2015–2017 and currently). She is also a member of the Spanish Association for Research in the History of Women.