

# Guidelines on Cultural Diversity and Health



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Departament de Salut

Print run: 1.000 exemplars

Publisher: Prous Science, S.A.

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Dipòsit legal: B-48334-07  
ISBN: 978-84-8124-251-5

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# **GUIDELINES ON CULTURAL DIVERSITY AND HEALTH**

Comitè  
Consultiu  
**Bioètica**  
Catalunya



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## ■ 1. INTRODUCTION

In recent years in Catalonia, we have seen how the presence of the immigrant population progressively changed the view we had of our neighbors, as well as the established co-existence habits of our cities and peoples, and we have been moving steadily towards *pluriculturalism*. As a result, an increasing need to provide healthcare to groups of people from very different cultures was brought about. Until a short time ago and for various reasons, there was not a high demand for specific healthcare which reflected this diversity in the health field.

The healthcare system cannot be oblivious to the changes taking place in our society. All people have rights, irrespective of their origin and culture. Firstly, they are entitled to the fundamental rights any member of the human species has; said rights are universally binding and concern particularly the institutions from all countries that have signed the Universal Declaration of Human Rights. There are also other rights that depend upon the legal recognition of a country's laws, such as the rights of citizenship, asylum and refugees, according to the requirements set by law. Besides, the Spanish Constitution stipulates, as a basis for the legal and political structure of the country, the recognition of the rights to freedom, dignity, equality and non-discrimination owning the ideology, religion, ethnic origin and gender, among others. These same rights are set forth in the 2006 Statute of Autonomy of Catalonia, Chapter I.

Respect for people's dignity, freedom and equality may give rise to questions when carrying out certain social practices. The healthcare environment receives many requests and even demands that professionals may question in terms of their social responsibility and commitment. The Bioethics Advisory Committee is increasingly receiving guidance and clarification requests regarding concrete problems.

Circumstantial casuistry does not seem to be the best way to face current problems. A comprehensive reflection is needed in order to understand the situation and set guidelines to address these concrete cases. That is the task proposed in this document, with the aim of helping pave the way to understanding cultural diversity in the health context, a task already initiated by other institutional groups.

### ■ 2. BASIC PRINCIPLES

There are some basic reasons that cannot be questioned and which are, in our opinion, the principles we must always bear in mind. In summary, they are the following:

#### ■ 2.1. Fair and equal access to healthcare

This means that adequate attention must be paid to information and admission tasks. Often users are not very familiar with the healthcare means at their disposal. Access to said means may also be hampered by language difficulties, economic problems or other problems.

It is always necessary to ensure that those involved in healthcare do not show more or less evident attitudes of racism, discrimination or a simple lack of consideration.

In this regard, it is necessary to put an end to inner barriers resulting from the lack of knowledge of the means available to the user. For example, knowledge of what they have a right to receive as part of their healthcare, or how to become part of the healthcare system; all these aspects can be improved by means of admission- and information-related tasks. But it is also necessary to bring down the external barriers some citizens encounter when they try to gain access to the healthcare system and are faced with more difficulties than the rest of the population either because they belong to a minority group or due to language barriers or economic reasons.

#### ■ 2.2. Respect for cultural diversity as an inherent value of human dignity

Another basic tenet of healthcare activities presumes respect for cultural diversity, an inviolable value inherent to the respect for people's dignity and to the free development of their personality.

This value is fundamental because it is necessary to understand that the perspectives relating to the causes of a disorder, the concepts of health and illness, the notion of the need to follow a treatment or the way to express symptoms vary

according to the cultural context and are not universal. It is also fundamental since this aspect favors a greater adherence to treatment and thus a better health outcome, both subjective and objective.

■ **2.3. Raising awareness of the different diagnostic and therapeutic choices of culturally competent healthcare**

This is another essential requirement for an effective healthcare which respects patients and communities from diverse cultural origins. From a Western perspective, conflict may arise with different interpretations of the healthcare model and can even lead to serious ethnic conflicts. The extent to which a patient can refuse to receive treatment on cultural grounds or the extent to which the healthcare provider should be understanding and offer alternative treatments, the safety and efficacy of which may be in question, are some of the situations which are increasingly arising from healthcare delivery to culturally different patients.

In this regard, the best policy is to take a respectful stance which does not come into overt conflict with the other person's consideration, and whenever possible favors a balance between the two views. Once more we must bear in mind that the aim of healthcare is to secure people's health and well-being.

■ **2.4. Actual exercise of personal autonomy and the right to information**

Respect for people's autonomy implies taking into account three main aspects: capability, information and willingness.

Informed consent is a cornerstone of medical practice, which allows the patient to exercise the right to decide, i.e., accept or refuse healthcare delivery.

This information, which shall be accurate, truthful, intelligible and tailored to each person's characteristics is considered in Act 21/2000 of the Catalan Parliament on the «rights to receive information in relation to health, patient autonomy and clinical documentation».

The Act reviews general rights which are not to be violated, but it cannot be very precise about the patients' actual needs. Such needs can be especially relevant when they are related to cultural diversity, since adaptation to each person's needs is more complex due to various reasons, such as communication difficulties, fears, complexity of the mechanisms that facilitate trust, or lack of knowledge about citizens' rights.

It is understood that a relationship with the patient must be established, since they are the ones who will make decisions regarding their illness and who will control the information they want to convey to their relatives about their health condi-



## 2. BASIC PRINCIPLES

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tion. But this is not always the case in community-based cultural groups. In fact, it is the family or the person in charge who waits for the first contact with the physician in order to control the information flow and make the appropriate decisions. For example, in the case of a terminally ill patient, the person in charge may choose not to tell the patient about his or her condition, in order to protect both the well-being of the patient and the group.

Ofentimes, the patient's friends or family consider that the patient is not capable of receiving bad news from a healthcare professional whom they regard, by definition, as being detached. It might be appropriate and in many cases respectful, for a person known by the patient to notify this information, whenever it is deemed convenient.

Although these attitudes deserve attention and respect, health professionals must make sure that patients take informed and autonomous decisions, despite the fact that this requires more time and effort when talking to the patients or their representatives. It is worth remembering that the hitherto ill-named «therapeutic privilege», i.e. not telling the patient that part of the information considered to be seriously harmful to his or her health, is not a standard to follow but an exception that must always be warranted.

Despite cultural differences, clinical information should be tailored to each patient's needs, a balance that may be difficult to strike but which must never be obtained by means of paternalistic omissions or defensive excesses.

### ■ 2.5. Respect for information confidentiality

Another issue that must be accurately tackled is the collection of information regarding cultural and religious aspects. This kind of information bears the highest degree of confidentiality granted by law, since this information is obtained because it is deemed necessary for delivering proper healthcare; it is necessary to bear in mind the constitutional principle of non-discrimination owing to belief, religion or customs.

An insight on different countries reveals that practices regarding this issue are diverse, due to the fact that this kind of information is relevant in order for the users of health services receive the appropriate healthcare. In some European countries these data are managed confidentially and it is considered discriminatory to categorize people by their cultural origin.

### ■ 3. COMMUNICATION AS A WORK TOOL

Communication is a pivotal element in the healthcare provider-patient relationship because patients' understanding of the situation and assumption of responsibilities, as well as their proper adherence to treatment, depend on communication. All these factors critically contribute to a favorable disease outcome.

Moreover, the importance of communication is even greater now due to the evolution experienced in the medical field in recent years. The healthcare relationship maintained some time ago was markedly paternalistic and the patient played a secondary role, while it was the physician who took control of the whole process, informed patients of their situation and managed their treatment. However, the autonomy principle is what currently prevails. It is the patient who has the final word regarding the proposals health professionals present in order to solve a health problem. This model fosters joint responsibility when making decisions. Therefore, it reflects the ideal of patient oriented medicine, in which the patient is regarded as a contributor, and not just the individual upon whom medical practices are performed. Given this context, the ethics requirements regarding informed consent become the ultimate guarantor of the patient's autonomy. It is necessary to provide information which is appropriate to the requirements of truthfulness, understanding and adequacy, so that it helps patients make the decision at their own free will.

Different kinds of obstacles often emerge when trying to engage in productive communication: lack of time, difficulties in coming up with simple explanations that are easily understood by the patient, relationship problems, misunderstandings. A communication event that might be difficult between people of the same culture may be even more difficult if it takes place among people speaking different languages and who have developed intellectually with very diverse sensitivities, concepts and notions of the world.

The fact that they do not share the same language is the first major obstacle. Nevertheless, the second obstacle is as relevant as this one: translated words may have a very different meaning according to the cultural referents they are associated with. That is to say, people may think they understand each other, when in fact the message sender and the receiver are thinking of different things. This can bring about very serious consequences.



### 3. COMMUNICATION AS A WORK TOOL

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The first obstacle is solved by means of translation. The second one, and especially for more complex cases, requires a person who can mediate between the two parts and who knows their respective cultures very well. In other cases, a certain degree of cultural sensitivity and competence by the professional will be enough to get the message through effectively. There are very simple communication resources that can be used in order to check if both interlocutors interpreted the information adequately. It is essential for healthcare professionals to be able to spot interferences that can stem from different ways of conceiving and experiencing such important human dimensions as time, space, diet, life and death, man-woman or parent-child relationships, social hierarchies and, of course, health.

Intercultural communication is not an object of study in this document. Nevertheless, it is worth remembering the huge number of factors, more or less subtle, which influence the outcome of communication between the healthcare providers and the patients; such aspects may result from each part's cultural origin. An example could be the kind of communication used, both verbal and non-verbal; whether it takes place in a high or low cultural context, i.e., if the structure of cultural meanings has a big differential value or not; the predominance of direct or indirect style; the way of expressing emotions; the different types of language and their meanings. All these elements, which have a great significance in ordinary therapeutic relationships, are even more meaningful when there is a considerable cultural difference between the patient and the healthcare provider.

Apart from cultural background and language barriers, which can themselves hamper communication between people of different origins, it is also relevant to mention the often precarious economic and working circumstances surrounding such barriers, an aspect that can in turn bring about new health problems. Health/disease processes cannot be approached without taking into account economic and socio-cultural conditions and experiences of the disease process nor can they be addressed without paying attention to the demands of citizen relationship and participation.

## ■ 4. IMMIGRATION STRESS

Some people coming from minority groups may bear particular psychological states requiring healthcare, but the stress immigrants suffer should be recognized as a clearly distinguished pathology.

All migration processes involve loss and benefit elements, which are inherent to the changes brought about when leaving the usual place of residence to move to another one which can be somewhat different. Such distance, both geographical and particularly cultural, results in subsequent efforts to adapt to the new living conditions. This adaptation effort can be defined as “immigration stress”. People who change to a different culture, such as the immigrants themselves, undergo unique stressful situations that the rest of the population can hardly imagine. Loss of status, marginality, alienation and perceived discrimination, coupled with the fragility of the person’s own cultural identity may become concerns that challenge the strength of their mental health.

Immigration stress occurs as the individual becomes unable to face either some concrete events or the chronic stress factors of everyday life.

Experts in stress caused by acculturation insist that what is important is not cultural contact itself but the stressing experience derived from such contact. The need to learn a new language, the different cultural codes and customs, the change in family and work roles, the lack of work permits or of a decent home can lead to considerable everyday stress.

It has been stated that stress due to acculturation has different components, such as nostalgia, the grief involved in leaving behind a particular way of life, the culture clash and the subsequent acculturation process or the frequent experience of discrimination.

### ■ 4.1. Nostalgia

This immigration stress source is the one associated with the losses related to leaving the country of origin and even missing basic aspects of life that initially only exist in the country that is left behind. Losing one’s friends and family, losing one’s



## 4. IMMIGRATION STRESS

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social status, job, language, customs and even territory may become significant stress factors, especially when they are accompanied by legal, work and social difficulties in the destination country.

### ■ 4.2. Culture clash

All stressing acculturation factors are related to living in a new culture, particularly including specially access to culturally-relevant services and products, cultural and religious activities, children's education and interpersonal relationships. Changes involved in the acculturation process frequently require individuals to adopt new roles, often culturally incoherent. Any radical change in cultural standards, such as in roles, may cause considerable stress.

### ■ 4.3. Perceived discrimination

Another potential source of stress is the discrimination perceived by the immigrant. This factor is not only related to stress, but also to the potential development of a psychopathology and other health problems. The experience of being discriminated on racial, religious or ethnic grounds accounts for an important part of some acculturative stress scales has been identified as a risk factor which predisposes people to physical and mental health problems.

Since what is involved here is the individual's experience, this factor is mostly influenced by personal perceptions rather than by actual objective discrimination. In fact, discrimination is not always obvious, since a large part of contemporary racism, for example, is implicit and remains hidden, even to the person who discriminates.

### ■ 4.4. Moderating and mediating factors

Although acculturation stress is not specific to any social class or to any particular immigration experience, immigration-related health needs are clearly governed by the context in which they take place. The model of stress-process suggests that specific individual and context factors act as mediators and moderators of the stress experienced by the immigrant.

## ■ 5. CULTURAL COMPETENCE

Although it is clear that no one can be expected to know the innumerable aspects of their patients' cultures thoroughly, it is advisable to strive to broaden one's knowledge about them and to adopt a flexible and open attitude, in order to accept cultural difference as something enriching that will lead us to be culturally competent in our profession.

The healthcare system should aim to provide equal quality healthcare to all patients, irrespective of their cultural origin. This purpose of «cultural competence» defined as the «set of behaviors, attitudes and policies which enable the system, the institution and/or the individual to function effectively with patients and communities from diverse cultural origins» involves, as Duna points out, «a fundamental change in the way of understanding, interacting with and thinking about the external world» which should be linked to better healthcare outcomes.

The concept of «cultural competence», which is still not so deeply-rooted in our field, is increasingly considered as one of the standards to be taken into account for quality healthcare.

Commitment to cultural competence must be achieved at two levels. The first level is individual and presumes that all participants in the healthcare process, from the clerk who receives the patient for the first time to the physician who performs the medical practice, should show cultural sensitivity towards others and try to acquire the knowledge, skills and attitudes which enable better intervention in the situation.

This ethical commitment, which should be required from all people who, governed by the value of health, carry out their professional activity in healthcare centers, would be futile if it were not accompanied by the relevant healthcare policies. It is this second level, the institutional level, that will make it possible to ensure that healthcare mechanisms are adjusted to user variability, an evident consequence of social pluralism. Any healthcare service should include among its quality standards the aforementioned cultural competence adjusted to each center's category and characteristics.



## 5. CULTURAL COMPETENCE

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### ■ 5.1. Cultural competence scheme

Based on the traditional model of what is regarded as a competent professional, it should be said that the basis of cultural competence is essentially made up of a specific set of knowledge, skills, attitudes and values.

#### ■ 5.1.1. Cultural knowledge

Cultural knowledge is acquired at two levels, one is general and the other is specific. At a general level, the health professional understands that culture, ethnic group, race and the migration process itself can affect personality development, value acquisition, the way to tackle personal problems or illness, social and professional relationships, as well as psychopathology and, maybe, its manifestation. At a specific level, the professional may even become acquainted with the cultural particularities of the different groups of patients he or she works with.

It is essential to bear in mind that a simplistic or coarse application of cultural knowledge, for example through stereotypes, can be more harmful than not using a cultural approach at all. It is beneficial to possess general knowledge about each of the cultures of our patients, since it can be useful as a starting point, but we must avoid falling into stereotypes, a dead end that causes one to pigeonhole individuals and ignore the distinctive features that may be present even among persons who belong to the same cultural group. A culturally competent professional understands that being part of an ethnic group is not a definite personality feature, but something that is interpreted and can be expressed in different ways. Furthermore, a culturally competent professional knows the acculturation and ethnic identity models and can apply them easily.

#### ■ 5.1.2. Cultural skills

Professionals who aim to be culturally competent must have enough ability to channel their patients' communication styles, values, beliefs and practices. In this way they will be able to spot the user's needs and to act in a way that facilitates communication with these people. On this issue we include skills both in verbal and non-verbal communication, as well as the experience needed to adjust communication to suit the interlocutor.

Below we present a scheme reflecting the different dimensions of cultural competence and the effects each one of them can bring about.

Dimension	Incompetent	Sensitive	Competent
Attitudes	Indefinite	Appreciation	Committed
Knowledge	No knowledge	Some knowledge	Broad knowledge
Skills	No education	Little education	Extensive education
Effect	Destructive	Neutral	Constructive

### ■ 5.1.3. Attitudes and values

Performance, i.e., the skills or “know-how” is based on technical and cultural knowledge (Knowledge, in a nutshell). But knowledge and skills are not enough. Attitudes, i.e., to know how to behave and act, are the basis upon which skills and knowledge must be developed.

The most frequent cultural competence models in Medicine focus on cultural knowledge and skills. However, medical research indicates that oftentimes the unequal treatment members of minority groups receive does not stem from a lack of knowledge or skills, but from stereotypes or discriminatory attitudes healthcare professionals show towards these patients. Professionals’ attitudes, beliefs and values in relation to the racial or ethnic group, and the cultural differences play a very important role, both in their relationship with patient and in the quality of the treatment. It is precisely for this reason that cultural competence models are increasingly demanding professionals to be aware of their attitudes and values, and of the fact that such elements have an influence on their intercultural work.

It is known that competence in relation to attitudes and values is not a concrete objective that can be achieved by means of a specific kind of education; rather it is a life-long process that involves moving from *ethnocentrism* to *ethnorelativism*, at least in a methodological sense.

In summary, it can be said that a culturally-competent healthcare professional is one who exhibits the following characteristics:

- Is developing an awareness of his or her values, concepts, prejudices, preconceived ideas and other personal limitations of cultural understanding.
- Tries to understand, actively and without passing judgment, patients’ cultural perspective.
- Develops adequate, sensitive and relevant strategies and interventions when working with culturally different patients.

### ■ 5.2. Performance standards

Although this standard is not covered in our local context, in other countries, such as the US, various measures have been adopted in order to achieve this competence. Some of the recommendations made by Americans can certainly be useful, but we should bear in mind that mimetic transpositions are not positive and that adaptation is needed.

#### ■ 5.2.1. Interpretation and intercultural communication services

The intercultural communicator is the person who, due to his or her knowledge of one or more cultural groups and their environment, acts as a bridge between the healthcare institution and the users, in order to provide the members of these groups with standardized equal access to social and healthcare services. Moreover, the intercultural communicator helps the various parties involved in the healthcare relationship acquire and apply adequate knowledge about their respective cultural and social views on health and illness.

On the one hand, the intercultural communicator advises professionals on a cultural group's characteristics and, on the other hand, informs the members of these groups about the current healthcare system in the community. As a mediator, the intercultural communicator must make sure that both the healthcare professional and the patient are able to communicate and talk to one another.

The profile of intercultural communicators also enables them to perform tasks in which they inform and accompany the users, according to the needs of the healthcare practice. The incorporation of the intercultural communicator in the healthcare setting is also useful to avoid forcing patients' friends or relatives to act as occasional interpreters.

With the incorporation of this figure, physician-patient communication has proved to be better in preventive medicine programs, in the user's degree of satisfaction and even in the overall cost of providing healthcare. Likewise, in cases where the healthcare system has not adapted sensitively to cultural differences, this figure is underused and even ends up being misused, with hospital emergencies replacing the general practitioner and with less treatment adherence.

For the good of all, access to such significant information as health-related information, together with the great impact healthcare may have, demands, a prompt and clear delimitation established by the administrations, which are responsible for the competences of this new figure, the intercultural communicator, as well as for their rights and duties within the required professional field.

#### ■ 5.2.2. Immersion in other cultures

Healthcare professionals must receive continuous training on how to work with people from different cultures. It is good that each center offers their staff the chance to receive training in order to gain an acquaintance of cultural characteristics of the diverse ethnic and religious groups of the community they work in and the impact those distinctive features have on the therapeutic relationship.

#### ■ 5.2.3. Culturally competent health promotion

Culturally competent healthcare includes the relevant fieldwork conducted to promote health among cultural minorities and groups. Some activities that may be performed include admission services, public education sessions, culturally-sensitive epidemiological studies and information and awareness campaigns adapted to cultural characteristics.

#### ■ 5.2.4. Community and family member inclusion

When working with cultural, ethnic or religious groups in the health field, contact with the leaders of the various groups is very important so that a communication channel can be opened up and health professionals can be adequately acquainted with the health needs of the members of these groups. It is advisable to establish connections between the healthcare administration (primary care centers, user services), and the most numerous cultural groups of the health community in order to strengthen this concept that requires addressing health issues in a multicultural context.

#### ■ 5.2.5. Administrative and organizational adjustment

In countries with a broad multicultural history, the healthcare system attempts to offer, whenever possible, individual or group healthcare provided by professionals with the same cultural origin as the patients. At the moment, this measure is not very feasible in our area and not everyone agrees with it.

### ■ 6. CONSENT IN THE CLINICAL RELATIONSHIP

Professionals should anticipate numerous aspects in healthcare; one of the main elements is the so-called *informed consent*.

This procedure is related to a person's right to autonomy, which is both legally and ethically acknowledged everywhere as one of the most important applications of the principle of respect for people and their autonomy. Respect for autonomy is regarded as a fundamental principle in bioethics, both in the field of biomedical research and in the healthcare activity.

We understand informed consent to be the patient's acceptance of a procedure, either diagnostic or therapeutic, after receiving the appropriate information to make an autonomous decision. This means that the patient must receive this information in an easy-to-understand way and must be informed of the expected benefits, the potential risks, the secondary effects that can result from the proposed techniques, and the alternative procedures. Therefore, patients must be aware that they can freely withdraw their consent at any time.

It is essential to regard consent as a dialogue process between the healthcare professionals and the users, in which they talk about those techniques that will be useful both for diagnostic and therapeutic procedures. This process takes time (sometimes more than one conversation), unconditional acceptance from the other party, empathic understanding and willingness to understand. Informed consent is too frequently mistaken for a simple bureaucratic practice consisting of signing some documents, which distorts the users' rights and reduces the possibilities of a relationship based on trust between patients and healthcare providers.

The law envisages the written formalization of the consent in cases of surgical intervention, invasive diagnostic procedures and, in general, in cases of procedures which may imply risks and serious and foreseeable problems which can have an impact on patients' health.

We should bear in mind that there are two caveats or exceptions in which informed consent need not be demanded. One is a situation posing an immediate and serious risk to the patient in physical and mental terms, which makes it difficult to secure the patient's permission. The other is a situation which poses a risk for public health, if the exception is required on health grounds pursuant to the law.

We must also consider other situations in which another kind of permission must be granted instead of this consent. This is done when the medical staff in charge or the healthcare team decide that the patient is not competent enough to understand the information and thus, to participate in decision making. In this case, the patient's relatives or representatives should give their consent. These exceptions also occur in cases of legally incapacitated people or those who are hospitalized due to a mental disorder; in said cases the relevant legal steps should be followed.

When providing healthcare in a culturally diverse context, the process which entails this principle of respect for patient's autonomy, i.e., informed consent, forces professionals to consider their practice within a framework of a more complex personal relationship. In this regard, we should pay attention to the following assumptions.

- Health professionals should consider the patients' actual degree of understanding of the information they have been provided, even if they may seem to have understood it. In order to guarantee this, it is necessary to be willing to repeat explanations, use explanatory graphic material and both verbal and written information and also to let intercultural communicators intervene if doubts arise.
- Healthcare professionals should make sure that the patient is making a sufficiently autonomous decision when accepting or rejecting the procedures proposed to him. Health professionals should also help patients strengthen mechanisms of trust and avoid any form of coercion. The point is that by trying to minimize the weak state of the person who feels ill, the reliability of an autonomous decision can be increased.
- It is also important to bear in mind that the concept of autonomy does not equal self-sufficiency. Our ability to make decisions is often influenced by social and personal factors. In fact, we can talk about different degrees of autonomy, depending on subjective determining factors involved in people's decisions, such as the fact that they are ill, or certain situations which are specific to some cultural groups, in which health-related decisions are not made individually but rather are shared with the group. Such is the case in groups who have a social idea of illness (when somebody in the family or the community is ill, everybody goes to see them, even relatives who live far away and do not even know the person). This would explain why obtaining consent may be delegated through authorized mediation. Despite this consideration, the informed consent document must be signed by the patient (if he or she is competent to make a concrete decision), and no other person can do it.

### ■ 7. DIAGNOSIS-RELATED ELEMENTS

Healthcare work entails a great interest in obtaining information about the clinical diagnosis and in identifying associated problems as soon as possible, in order to subsequently focus the adequate treatment plan.

Despite the advances made in diagnostic techniques in recent years, a patient's history, based on the physician's symptom interpretation, is still a fundamental tool of the diagnostic process, in which once again adequate information is essential.

First of all, it is necessary to find out why the patient came to see the physician, since the resolution of symptoms is not always what the patient is looking for. Cultural diversity requires even more that health professional make an effort to interpret symbolic codes used by the patients, in order to get to know their actual health needs. It is also important not to mistake medical problems with situations resulting from other types of problems: economic, social or cultural. Medical intervention in areas beyond the realm of medicine is a characteristic of our times and contributes to losing sight of the measures that can redress the aforementioned imbalances.

Inadequate communication is a potential source of diagnostic errors. Subjective symptom interpretation has cultural nuances. Likewise, the physician's interpretation is also made from his or her own cultural perspective. For this reason, it would be advisable to make an effort to move away from our cultural referents in order to observe our patients more objectively.

Health-related complaints are expressed in very different ways in different cultures. Knowing these variations when symptoms are described may be very useful to prevent diagnostic errors. Although it is clear that nobody can expect to know the countless aspects of the patients' cultures thoroughly, we can make an effort to broaden our knowledge about them and to take a flexible, open attitude in this regard.

Before informing patients about the relevant additional examinations needed to diagnose their disease, it is suitable to solve language difficulties with them or, if such is the case, with the patient's representative or with the intercultural communicators themselves, if they are necessary.

In summary, providing healthcare to people from different cultural origins involves a relationship scenario which is more unstable than the usual one and involves certain specific characteristics.

- Providing healthcare to these patients requires more time.
- We should avoid thinking that culture explains everything. Denying cultural influence on symptom onset is as dangerous as trying to justify any anomaly because the patient belongs to a given cultural group.
- It is necessary to adapt the ways in which autonomy is exercised to the cultural peculiarities of the patient.
- We should bear in mind that some mental disorders, such as depression, may often bear symptoms that can sometimes be expressed differently depending on the diverse cultures. This type of physical symptom often enables patients to have simpler, more direct access to the healthcare system than referring psychiatric symptoms.
- Since in some cultures the professional's interpretation of the symptoms and the decision upon the treatment to be followed are almost immediately associated, on many occasions it is convenient to adequately inform patients that they will have to undergo examinations (analytical, radiological and instrumental) in order to be accurately diagnosed.
- Sometimes a third person may ask to be present during the clinical visit. If in these cases a third person's presence is considered to have been imposed, it is convenient to ask the patients to give their consent about it.
- Privacy and confidentiality concepts do not have the same meaning in all cultural systems. Therefore, such diversity should be taken into account in this regard.
- All aspects related to informed consent, as pointed out before, should be taken into account when performing examinations requiring instruments.

### ■ 8. TREATMENT-RELATED ELEMENTS

Cultural elements have a powerful influence on treatment outcomes. Compliance with and adherence to the therapeutic process, the placebo effect of drugs or the response to them are some of the behaviors that may be influenced by the fact that the patient belongs to a specific cultural group.

In the therapeutic aspect, the healthcare relationship will have different connotations, according to the goals of the healthcare practice: prevention, healing or just advice. We must make sure that the basic mechanisms that make trust possible in the clinical relationship are effective enough to achieve the shared therapeutic goal.

In order to include the patient as a participant in the healthcare process, we should pay attention to the basic reason why he or she came to the center. Paying attention to symptoms is essential to establishing a relationship of mutual trust. Later on, this relationship may include talking about self-awareness of the disease, a key element to subsequently establishing a therapeutic plan. It is known that in some cultures health-illness processes are closely connected to symptoms. Such cultures do not have a tradition of preventive medicine (there is no need to cure something which has not become evident yet) and people are only aware of being ill when symptoms appear hindering their normal development. It is likely that patients do not understand what preventive medicine means.

Nor can they understand why a tablet has to be taken three times a day or with meals, or for months, if symptoms have already disappeared. However, if patients are given reasons for this and it is confirmed that they have understood such information, these potential problem sources may be reduced.

In Western culture, illness is often regarded as an entity itself, with a pathophysiological origin which explains it. Because of this, it can be specifically treated. But in other cultures this perception is a little different. This is particularly relevant in cases of psychiatric disorders, in which divine, religious or spiritual reasons may explain such behavior; therefore, the situation is not experienced as a disease itself.

Patients belonging to these cultures often use both the medicines prescribed in the healthcare system and traditional medicines. In such cases, it is recommended to be tolerant and respectful of this dual treatment, unless there is evidence that it may be harmful to the patient's health.

We must also bear in mind that there are biological differences that may account for different responses. For this reason, it must be understood that we do not always deal with patients who demonstrate critical behavior with the prescribed medication.

## ■ 9. HEALTHCARE CENTERS' RESPONSIBILITY

Respect for cultural diversity in the area of healthcare centers is in line with the concept of corporate social responsibility and is placed at the top of institutional management. This is so because these responsibility areas are the backbone of the fulfillment of current health legislation, and from such areas ethically appropriate decision making is fostered and accomplished in order to improve the health and quality of life of citizens in general and of the healthcare center users in particular.

The concept of corporate social responsibility in the healthcare area includes behavior codes that ensure that ordinary center activities, both in the internal and the external setting, are sustainable and do not threaten social rights or the environment.

Within this context, it should be pointed out that cultural diversity in our society is a reality which should not be overlooked under any circumstance. Cultural diversity has been gradually incorporated in Catalonia as people from other places came to settle here, either for a relatively long period of time or permanently.

### ■ 9.1. Relevant aspects of healthcare centers' responsibility: citizens' admission to centers

In terms of health and healthcare, the Generalitat of Catalonia Charter of Rights and Obligations of the Citizens, approved on July 24, 2001, includes a specific mention about equality-related rights and non discrimination in access to healthcare services. This is mentioned in point 6 of the introduction which says:

«According to the Constitution, people are equal in eyes of the law and shall not be discriminated owing to birth, race, sex, religion, opinion or any other personal or social factor or circumstance. In the health area, non-discrimination causes shall be understood as being supplemented by those included in the relevant international agreements ratified by the Spanish State.

There is, however, a concept of positive discrimination, when these differences or distinctions between people are motivated by a need to protect the most vulnerable ones.

Within a context of limited means and resources, the need to prioritize healthcare requires the inclusion and appreciation of the demands and interests of the whole population. In this context, the criteria that should guide prioritiza-



## 9. HEALTHCARE CENTERS' RESPONSIBILITY

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tion in terms of access to healthcare services are the following: the severity of the health problems, effectiveness of the proposed treatments and egalitarian access, always bearing in mind respect for the difference in the most vulnerable groups.

This programmatic principle of the Charter of Rights and Obligations unquestionably establishes the scope of the right to human dignity respect as a fundamental value, irrespective of people's origin, culture or religion.

This means that, applying the principle of equality, all patients and their relatives should be treated equally and under no circumstances should they be treated in a different way which is not consistent with the criteria aimed at prioritizing access to healthcare services.

### ■ 9.2. New conditions in healthcare centers

Due to the changing circumstances arising from the incorporation of people and groups with different cultures and values in our society, healthcare centers must be adapted to new emerging needs. For this reason, the following objectives are to be included in decision making regarding the planning and management of available resources in each center:

- Ensuring reception at healthcare centers (first access) based on personalization of the reception and on an agreed protocol adapted to territorial differences and to the environment of each healthcare center.
- Building an atmosphere of respect and welfare among the people pertaining to the health community (patients, relatives and professionals) which avoids discriminatory attitudes or any other attitude contrary to universal access of people to healthcare services.
- Foreseeing the availability of suitable places for religious ceremonies, so that adequate privacy can be maintained.
- Incorporating menus and culinary characteristics typical to other cultures into dietary offerings.
- Encouraging the hiring from competent persons of other cultures for available job positions.
- Including the adaptation and translation into the prevailing languages and cultures of the healthcare community of the information contained in the programs of instruction and documentation and information distribution needed to move around in healthcare centers.

- Setting up the conditions necessary for the exercise of rights and fulfillment of duties for the whole population.
- Ensuring the same degree of satisfaction and excellence for all users, based on respect for rights and duties and for all levels of scientific, technical and human quality in the healthcare sphere. Perceived quality assessment indicators will adapt to the cultural diversity of the population groups receiving healthcare at the center, both as regards service quality assessment and with respect to people's expectations about the healthcare they want to receive from the healthcare center and from the professionals working there.

In order to meet both these requirements and address new aspects related to cultural diversity and human resources management in the centers, healthcare professionals will need to have access to knowledge about the basic characteristics and the cultural identity defining the population that receives healthcare at the center: customs, family relationship dynamics, the concept of personal autonomy, differing perceptions and interpretations of the concept of health, etc.

Furthermore, it will be necessary to guarantee all professionals and employees in the center access to standards (laws, protocols, guides, etc.) in order to ensure the appropriate implementation of legislative and deontological innovations and to have the possibility of employing advisory support for their profession in the field of cultural diversity.

### ■ 10. PROMOTION DEBATE IN HEALTHCARE INSTITUTIONS

One of the roles of healthcare administration is to plan and organize healthcare policy, i.e., to set up the framework and the criteria according to which healthcare is provided. Another role is to render services, either directly or through different providers.

Regarding the first role, we should bear in mind that in democratic societies the decisions made in relation to healthcare policy are to be reasoned out and backed up. These policies should be aimed at ensuring the right to an appropriate minimum degree of healthcare within a distribution framework which should be as fair as possible and should counteract the lack of possibilities resulting at random or from social situations people cannot control.

The principle of *equality* should always be supplemented by the principle of *respect for people's dignity*, which includes respect for different cultural expressions in relation to healthcare. The Administration should require people providing this service to always take cultural diversity into account.

Nevertheless, we must admit that it is not easy to make decisions that reflect equal respect for the different moral beliefs and the existing practices in a plural society. Despite all the provisions of laws, codes and recommendations, a wide range of unforeseeable situations always exists. For this reason, reflective groups, such as healthcare ethics committees, may be of help and could be the institutions which encourage debate and make it possible. In fact, many of the controversies regarding the refusal of treatment or requests for attention to certain practices and beliefs specific to some groups have already been discussed in these areas.

Therefore, one of the initiatives the Administration should foster is the promotion of bioethical debate, both at the centers themselves and through healthcare ethics committees, such as the Catalan Bioethics Advisory Committee itself.

## ■ 11. SOME CONCRETE SITUATIONS

Some of the concrete situations presented below have generated recommendations in different instances of debate and consultation. Therefore, they should not be interpreted as an indication or as the only way to proceed but as elements that should be taken into account when making decisions in similar situations.

### ■ 11.1. Accessibility to the healthcare system

It is often said that culturally-different patients neglect their medical appointments, because, for example, they are absent or late for them. Of course there are people who do not go to their appointments because they do not want to, and such cases cannot be justified. We should pay attention, however, to other very different cases in which people do not go to medical appointments due to reasons related to the healthcare reality of their society or culture of origin.

In some countries, seeing the doctor consists of going to a walk-in clinic where whoever needs healthcare receives it for whatever reason, with no need for an appointment. The physician sees the patients in order of arrival, until completing his/her working hours, and those patients who could not be seen by the physician that day are left for the following day. Additionally, it is worth remembering that in some cultures family obligations take priority over personal needs. That is perfectly natural for people from these cultures, and thus if they had to choose between going to the doctor or staying at home because a relative needs them, most of them would choose the latter. The solution to this kind of problem, which would in turn facilitate access to the healthcare system, is, again, related to appropriate information about the characteristics of the system. For some new arrivals to the country, this could be very new, but they would eventually end up acquiring the habit.

### ■ 11.2. The presence of the husband at his wife's appointment

Another situation that is increasingly seen within the framework of multicultural coexistence and which many healthcare professionals complain about is the «pres-



## 11. SOME CONCRETE SITUATIONS

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ence of the husband at his wife's appointment». Again, this is an area of friction that requires analysis from an open cultural perspective, in order to at least understand what standards dictate this behavior.

One's initial interpretation is that women are deprived of their freedom. However, this practice may, on the other hand, be considered as a husband's or partner's obligation to safeguard and supervise his family's health, in which case he will not allow his wife to go to a medical appointment unaccompanied. This demonstration of interest gives him a leading role; he informs the physician of his wife's symptoms, brings along the healthcare certificates, receives the prescriptions, etc., just as all parents do with their children in other cultures. The healthcare professional has the obligation to promote autonomy in their patients' decision making and to reject any kind of coercion that may occur.

### ■ 11.3. Healthcare provided by a same-sex professional

In some cases, patients ask to be seen by a professional of their same sex. The Charter of citizens' rights and duties in relation to health and healthcare offers all users and patients of public healthcare services the chance to choose the professional and the center, for primary and specialized care as well as for social healthcare, according to established terms and conditions and depending on availability in the public healthcare network. The center will guide and inform users and patients about this right and will facilitate the data needed to gain access to these services.

### ■ 11.4. Some problems in intercultural mediation

The means of conveying of healthcare information may not be the most appropriate for the patient. This problem may arise when the person appointed to receive the information (medical interpreter, healthcare agent, intercultural communicator) is given an inappropriate role in the process, or when information is conveyed by someone who is not able to do so for emotional reasons, for example a relative or a child who must talk to the patient about sensitive issues, or when the person is not an expert in interculturalism.

Regarding the first of these cases, healthcare professionals often do not want the intercultural communicator to act as such, i.e., they do not want him/her to actually participate in the three way interview but to act as if he/ she were their representative. These situations take place when the health professional says, for example: «Tell her that she will be operated on tomorrow and that she has to be ready», or «Tell him that he has this disease and that the treatment will consist of

his taking these tablets», or even «Explain to his parents that we did everything we could, but the boy is seriously ill and he may not live». It must be recalled that the healthcare professional is the only one responsible for communicating such information to patients and that the intercultural communicator's role is to facilitate such communication, rather than to replace it. Just as when a nurse or physician visits a patient who knows the local language well and it is this professional who talks directly to the patient, we should do the same with people with language difficulties; we should not incorporate a third person, who is not a healthcare professional, to convey the information.

Research on translation errors (omissions, additions, changes) show that a professional translator may make mistakes that can have a serious impact on the healthcare process. We can therefore assume that a person acting as an intercultural communicator, whose preparation as such is insufficient, demonstrates a greater risk of making more serious mistakes in this regard.

It is clear that the person acting as an intercultural communicator in a three way interview controls the information being exchanged between the healthcare professional and the patient. As a result of this, it is convenient to mention the intercultural communicator's presence and participation in the patient history and also to demand the respective confidentiality from said individual.

#### ■ 11.5. Children as mediators

For situations where children are used to convey information, we should bear in mind that this practice poses many dangers, both for children and for their parents. Children are exposed to certain information about their parents, for example, to private issues, and they also abandon their role of child to adopt one of an adult.

The practice of having children act as translators seems to be a common "last resort" alternative, due to the lack of qualified professionals. However, this practice cannot be accepted as normal, although the healthcare professional may assume responsibility for allowing it, depending on the situation. This unacceptability should serve as an argument to support the incorporation of intercultural communicators, as set forth in the "*Plan director de la inmigración*".

#### ■ 11.6. The right to preserve cultural habits

Patients, their families or those related to them may behave in a way different from what is established by the rules of the healthcare center. For example, they may want to take food into the patient's room, or it may be common to have many peo-



## 11. SOME CONCRETE SITUATIONS

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ple together at the patient's bedside at the same time. Some of these situations may clearly affect healthcare practice, but some others do not necessarily have such an impact. It is very important for professionals to adopt understanding attitude regarding the adaptations needed for each person's case. For this reason, flexibility in accordance with the standards and functions of the department must be ensured, in order to guarantee high-quality healthcare for the patient. We can say, based on experience, that these situations can often be resolved with the willingness of both parties to employ dialogue and agreement.

### ■ 11.7. Refusal of treatment based on religious beliefs and other reasons<sup>1</sup>

Healthcare proposals are always aimed at doing good (principle of beneficence), i.e., at working to improve the users' health, as well as their quality of life. Healthcare professionals formulate these proposals because they think they respond to these goals. But they must make certain not to put forward impositions, but rather actual proposals, since quality of life is primarily defined by autonomy.

The healthcare professional may think that one therapeutic choice is better because, for example, it can improve the patient's survival or it can cause him/her less suffering. However, the patient may have an opposing view, due to religious beliefs or other reasons.

Quality of life is certainly a subjective concept that can vary from one person to another. If the conditions of the autonomous decision meet all the requirements (information, capability and willingness), respect for the patient's will is clearly the priority.

The obligation of the healthcare professional is never to proceed in a harmful manner. They are to avoid any action that could cause harm. They are, instead, expected to propose the actions they find appropriate. This second obligation, in line with their role to do good or beneficence, has a limitation: the consent of the patient himself. On some occasions, and due to religious beliefs or other reasons, when a patient rejects the healthcare professional's proposal, it is necessary to consider whether it is appropriate or not to administer a treatment to a person whose life is in danger. In order to consider this, we must consider that these patients' requests do not reflect a wish to die, but instead that they are related to the respect they have for their religious or moral beliefs. For them, life makes sense with this refusal. It is clear that religious and moral dimensions are important and that we no longer live in a society with a uniform code, upon which a particular

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<sup>1</sup>The standing of Catalonia's Bioethics Advisory Committee, of April 9, 2003, can be found at: <http://www.gencat.net/salut/depsan/units/sanitat/html/ca/consells/spbioe00.htm>

view of life, whether religious or not, is imposed. A plural and multicultural society brings about such situations. Taking into account all of the above, it is difficult to consider it harmful, from an ethical point of view, to not administer a treatment to a patient who so expresses.

The Catalan public healthcare system is a tool aimed at enabling a more equal society. For this reason, any person can have access to this system simply because they are citizens. Although the kind of healthcare services delivered depends on the political agreement reached via representative democracy, which is performed in a certain offering, the National Healthcare System has to promote effective actions to be taken in order to improve health and has to be respectful to the rights of the infirm.

Likewise, a plural society has to be sensitive to the different cultural groups and minorities in its midst and try to provide an answer to their requests, as long as no legal or ethical element to the contrary is involved. This social response may have another limitation: the cost of alternative treatment, if it is higher than traditional treatment and there are no institutional measures to bear that cost. The legal obligation is to provide healthcare that shows respect for religious, moral and cultural considerations, without that entailing an imposition on the healthcare professionals nor something unfair, such as a higher treatment cost. Therefore, we should consider risk in an objective way, since this concept is sometimes unreasonably exaggerated,, and we should implement protocols aimed at preventing stigmatization and discrimination against patients.

#### ■ 11.8. Demand of virginity certificates<sup>2</sup>

Virginity, understood as the result of the absence of previous sexual activity, cannot be literally certified because neither a physical examination nor any other test can provide or attest to that information.

The physicians of the National Healthcare System are only required to certify a person's health status and to issue reports in relation to the health rights derived from the right of access to economic and supplementary services that the Administration provides to citizens.

Respect for each person's moral and cultural values as well as for their religious beliefs should be consistent with an appropriate medical practice aware of the common values and rules of the society in which said practice takes place.

<sup>2</sup>The standing of Catalonia's Bioethics Advisory, of October 10, 2001, can be found at: <http://www.gencat.net/salut/depsan/units/sanitat/html/ca/professionals/virginitat.htm>

### ■ 11.9. Circumcision

The national healthcare system is not to provide nor to finance the treatments or medical practices required by the particular cultural beliefs which are not considered medically relevant to people's health. This is established according to the principle of justice, which states that available means shall be equally distributed. Therefore, it is clear why traditional practices such as circumcision are not covered herein.

The situation differs in cases where such practice is medically recommended and a medical decision is made in this regard.

### ■ 11.10. Female genital mutilation

Respect for cultural diversity or for a person's dignity cannot accept certain practices that are contrary to personal integrity or to human rights, as that would constitute a flagrant contradiction.

Recognition of the unique value of each person and their freedom is in line with the general framework of protection of all people's physical and moral integrity, whereby freedom of religion and the practices related to specific convictions should be consistent with the protection of one's moral and physical integrity and that of others. This is an ethical principle and a constitutional mandate, which is seen in various laws of the Catalan and Spanish legal system. These standards are in line with the ethical commitment institutions and individuals should make as regards people's sexual and reproductive rights. This responsibility that must be particularly required of all heads of family (fathers or others) and healthcare professionals.

Likewise, article 24.3 of the Convention on the Rights of the Child (November 20, 1989), adopted by the United Nations General Assembly, establishes that: «States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.»

Female genital mutilation, in any of its forms, is a crime of injury, classified and punished by our legal system (articles 147, 148, 149 and 150 of the Penal Code and the Fundamental Law 11/2003 dated, September 29, on concrete measures regarding citizens' safety, domestic violence and social inclusion of foreigners, published in the Official State Bulletin [BOE] issue 234, dated Tuesday, September 30, 2003) Legal action should be, in any case, the last resort to be employed when faced with the behavior we seek to have avoided.

Catalan institutions have worked hard over the last few years to control these situations. The Catalan Parliament, in the session held on June 20, 2001, approved Resolution 832/VI on the adoption of measures to prevent the practice of female genital mutilation and urged the Generalitat to create an interdisciplinary expert

commission, in order to devise a plan of action to combat the practice of female genital mutilation in Catalonia. Later on, in 2002, the *Protocolo de actuaciones para prevenir la mutilación genital femenina* (Protocol of actions aimed at preventing female genital mutilation) was published. It was developed by the interdisciplinary commission, with the participation of diverse technical experts from the Health, Home Affairs, Justice, Social Welfare and Education Ministries, as well as from the Presidency through the Catalan Institute for Women and the Immigration Secretariat. This Protocol also mentions the work carried out by the Subcommittee on Female Genital Mutilation of the Commission on Domestic Violence of Girona.

In 2004, the Midwives Association devised and published the manual: *Female Genital Mutilation: prevention and healthcare. Guide for professionals*, within the framework of the IDIL Project [Instruments to develop the integrity of lasses (2001/2003)] of the European Program DAPHNE. This guide was published again and translated into Catalan in 2006 by the Catalan Health Institute.

This wide range of materials enables us to enhance our knowledge of female genital mutilation from different perspectives, enriching understanding and also making intervention proposals as well as suggestions for strategies aimed at preventing this practice, promoting information, education and respect for human rights as the basis of prevention.<sup>3</sup>

Taking into account our context, it is worth highlighting some remarks and recommendations included in these documents:

- This practice is not to be related to religion, but rather to culture.
- The fact that female genital mutilation is a cultural tradition does not mean that it is not run counter to universally recognized rights.
- Only efforts aimed at improving women's social and economic status, together with education in their communities, can alter this practice.
- We should focus intervention in families from an overall perspective, aimed both at women and men.
- Families need to receive support in a sensitive and non-sensationalist way, in order to avoid negative and distrustful reactions.
- It is very important to carry out information and education tasks with the participation and cooperation of the communities affected by these practices.
- It is necessary to raise awareness among the relevant authorities.

<sup>3</sup><http://146.219.26.6/depsan/units/sanitat/html/ca/dir441/doc10503.html>



## 11. SOME CONCRETE SITUATIONS

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- There should be cooperation (information, education and dissemination of information) among all institutions and people that may participate in the process of identification of female genital mutilation.
- Mediation in families at risk of genital mutilation should be fostered, with the participation of experts and people in the community who are affected by these practices.
- We need to make sure that victims of female genital mutilation receive psychological support and assure that their genitals are surgically repaired within the public healthcare system, if so they wish.

### ■ 11.11. Healthcare workers' moral convictions

Problems that healthcare workers may have in their different professional categories due to conscience-related reasons or moral convictions need to be clearly defined and circumscribed. Until now, these problems were usually restricted to the sphere of physicians and to their objection to certain procedures (abortion) or to the prescription of certain medicines.

The incorporation of people with moral convictions different from the prevailing ones can extend this problem to other healthcare workers and professionals, such as care providers, assistants and nursing staff.

The person who was hired for a specific service and whose professional obligations were clear cannot cite issues of morals or conscience. The most natural way to proceed would be not to have chosen that job or to have left it voluntarily, when moral issues emerged.

The situation differs if a person was hired for a radically different job, for which they were not expected to perform certain tasks, and were later on transferred to a different position for organizational reasons. In this case the institution should be more sensitive to the person's moral objections.

### ■ 11.12. Biological materials donors motivated by economic reasons

Some medical practices require people to donate biological samples or gametes or to participate in clinical trials, for which they are financially compensated. Some people from countries with a much lower economic level may be persuaded to take part in these experiments or to donate biological materials for economic reasons. Centers and researchers must be honest and they must not specifically address enrollment/recruitment campaigns to these groups, since they are frequently more vulnerable.

Respect for the law is inherent to the ethical behavior of all parts involved: participants in research or donors of biological samples and healthcare professionals and researchers. There may be some behaviors which are not necessarily against the law but which are ethically reprehensible. The Belmont report, one of the basic texts in Bioethics, reminds us of this when it says that for people taking part in investigations (also applicable to the donation of biological materials), informed consent shall be obtained without undue influence on the subjects; this is what can happen in cases when an excessive, unjustified, inadequate or incorrect reward is given. It also says that some rewards which are usually considered to be appropriate can be deemed otherwise when they are offered to particularly vulnerable people.

#### ■ 11.13. Access to reproductive healthcare services

Some health indicators from a gender perspective, such as voluntary termination of pregnancy, violence against women and sexually-transmitted diseases, among others, show higher rates of occurrence among groups of immigrant women, especially during their first years as immigrants.

This data reveals the group's vulnerability regarding affective-sexual and reproductive health and provides evidence about the difficulties people encounter in access to preventive resources in the healthcare network, especially in primary care. Because of this, awareness programs for this population are recommended, in order to facilitate benefits and knowledge regarding these services.

#### ■ 11.14. Medicalization as a response to social problems

The healthcare system is often the most recognized institution and the one with the greatest response capacity. In fact, the first document immigrants obtain is their health card, and many of them are first received into the country by a healthcare professional. Therefore, it is not unusual for the system to receive requests for medical solutions to problems pertaining to other areas.

A wide and holistic notion of health is certainly in line with the idea that professionals must take into account the set of factors which affect people's health: housing, food, solitude, education, etc. The healthcare system is not responsible, however, for demands of a social or cultural nature. However, without losing sight of a comprehensive approach, the system must refer people with such problems to another institution that can provide a solution for them.

It is not suitable to foster excessive protectionism through special programs which would contribute to the medicalization of people's everyday problems and habits, since this would not only reduce their autonomy but would also encourage a lack of responsibility on the part of the subjects and their families.

### ■ 11.15. Dietary habits

Dietary habits often depend on religious standards and on rooted cultures or convictions. The document «Guide to respect for religious pluralism in the hospital setting» (2005), from the Presidency and Health Departments, specifies the diversity of existing practices in the communities living in Catalonia, as well as their link to some time cycles and celebrations.

Healthcare centers can hardly deal with all these diversity issues, but by making some small changes a variety of options can be offered in order to meet the most basic needs of large groups of believers. Avoiding pork, facilitating vegetarian diets and allowing fasts as long as they are not clinically contraindicated should be accepted within reasonable margins.

### ■ 11.16. Genetic studies in ethnic groups and the danger of discrimination

Current knowledge of genetics shows us that it is suitable to conduct studies on the population or on particular groups in order to obtain specific analytical data. When these procedures are performed, special attention must be paid to the confidentiality of the data, with genetic counseling and with fair and non-discriminatory treatment. In recommendation 12, the European Commission document «Twenty-five recommendations on the ethical, legal and social implications of genetic tests», establishes that:

«As regards genetic tests, there may be a differentiation of the patients' populations, depending on the ethnic group. Some genetic variants are common in certain groups or populations, either inside or outside of the EU. Special attention shall be paid to these groups when tests are performed, following the established conditions for the use of such tests, in order to ensure fair access and prevent stigmatization and stereotypes. In short, genetic tests are not appropriate to determine a person's ethnic origin and are never to be used with that aim.»

The 12th recommendation below indicates:

- a. Genetic tests should be clinically evaluated in the populations in which they will be used.
- b. People participating in the genetic investigation, the performance of the genetic tests and the design of healthcare policies should be aware of the risks of falling into stereotypes and of stigmatization due to ethnic origin, and they should recognize and respect ethnic and cultural sensitivities.

- c. Ethnic minority groups are not to be excluded from the genetic tests appropriate for them.»

#### ■ 11.17. Respect for religious beliefs

Coexistence in plural societies such as Catalonia's should be in line with a commitment to the defense of a civil ethics shared both by believers in different religions and by non-believers. Based on the values, rights and duties of civil ethics, one should be afforded the possibilities to express a moral based on faith or not, with the project for a happy and virtuous life this produces.

Respect for freedom of religion and worship and the right to the social exercise of religion is to be consistent with the exercise of rights and duties of citizens regarding health and healthcare.

Conflicts resulting from situations related to the users' adherence to different religious groups may be resolved, in most cases, if we bear in mind some basic elements set forth in the *Guide to respect for religious pluralism in the hospital setting* of the Generalitat of Catalonia (2005). Some recommendations from this document are highlighted below:

- Seek to respect and meet, as far as we possibly can, the requests made by the patients in relation to their beliefs, as long as they do not run counter to the law, they do not disturb the rest of the infirm people and they do not entail extraordinary public expenses.
- Costs derived from medical practices specific to some beliefs are not to be borne, unless they are medically relevant.
- Hospitals should guarantee patients that they can receive religious assistance if they so request. Non-believers are not to be questioned about their beliefs, nor are they to be offered healthcare services intended for believers.
- Professionals working at healthcare centers should be specifically trained in issues related to rights to freedom of thought, religion and conscience.
- Healthcare centers should provide a neutral area where people can meet their religious or worship needs.

#### ■ 11.18. Management of birth and death processes

Birth and death represent the extremes of a person's life: both events involve customs and rites with a marked cultural component; for this reason, we must consider some aspects related to them.



## 11. SOME CONCRETE SITUATIONS

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In the birth process, the professionals involved must be particularly sensitive to cultural differences, in order to be able to develop strategies aimed at favoring communication.

We should also pay attention to the perception both the man and the woman have about this event in their lives, their expectations, ideas, fears, previous experiences, need for support, preferences, how they expect to experience their child's birth and their cultural view. In the Health Department's Protocol on labor and puerperal assistance and assistance to newborn (2003), the Protocol on pregnancy monitoring in Catalonia (2005), the Guide to respect for religious pluralism in the hospital setting of the Generalitat of Catalonia (2005) and the document on anticipated wishes, we find diverse guidelines for approaching childbirth and some rites that are to be considered.

The death process and the rites related to it are crucial moments in a person's life and in their relationships with other people. On the one hand, it is essential to provide all possible human assistance and healthcare in the final phase of a person's life and, when therapeutic measures fail, pain should be alleviated as much as possible. On the other hand, when death is impending or it has already occurred, we must pay attention to understanding and respecting the customs and rites related to it, which are characteristic of the different communities of believers and non-believers.

Again, we must mention the Guide to respect for religious pluralism in the hospital setting of the Generalitat of Catalonia (2005), where the various rites and ways of handling the corpse are specified, and they should be used as a guide to organize areas and services.<sup>4</sup>

Apart from usual situations, the guide also deals with some particular cases of people with a terminal disease who ask to be transferred to other countries or Spanish regions in order to die surrounded by their family members. Administrations must be sensitive to the aforementioned situations and must seek to provide support to these people.

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<sup>4</sup><http://146.219.26.6/depsan/units/sanitat/html/ca/infantil/index.html>

<http://146.219.26.6/depsan/units/sanitat/html/ca/dir441/doc10503.html>

## 12. HEALTHCARE ADMINISTRATION INITIATIVES

Apart from the initiatives it typically adopts, the healthcare administration has taken some measures to foster healthcare which shows respect for citizens' cultural diversity. The following measures can be highlighted:

### 12.1. The Charter of the rights and duties of citizens

This is the programmatic document approved by the Government which acknowledges, among others:

I. Benefit from the rights recognized in this Charter in a non-discriminatory context. Enjoyment of the rights and liberties set forth in this Charter shall be ensured without discrimination on any grounds, such as sex, race, skin color, language, religion, political ideology or ideology of any other nature, national or social origin, belonging to a national minority, property, birth, genetic heritage, the illness the patient is suffering or any other condition.

II. Right to freedom of ideology, religion and worship. All people are entitled to have their moral and cultural values, as well as their religious and philosophical convictions, respected. Any practice derived from that shall be consistent with medical practice and shall respect the center's rules. In the event of hospitalization, people's right to reject or to receive spiritual help shall be respected, regardless of their belief.

III. Right to informed consent and to the broadest interpretation of same. From treatment refusal to anticipated wills, this right is largely protected under our legal system and it is one of the main contributions to Bioethics. It is certainly an element that is vital to ensuring respect for the diverse ways to conceive of health and healthcare which aims to overcome medical paternalism and submissiveness to medical authority. It is worth remembering that by asking for consent we are giving the other person the possibility to refuse the healthcare procedure or treatment, although such intervention may mean an improvement in health status and may even save the patient's life.

### 12.2. Guide to respect for religious pluralism

The Guide to respect for religious pluralism, published by the Presidency and Health Departments in December 2005 stems from the reality that Catalan society is characterized by secularism and, at the same time, by an increasing religious pluralism. As a result, patients participating in the healthcare system have a great variety of beliefs, thanks to immigration.

The guide has three purposes: First, to provide information to all healthcare professionals about the potential religion-related requests people admitted to a center may make. Second, to make everyone aware of how important it is both for the members of the different religious groups and for the people who do not belong to any such group to feel that their convictions are respected, especially when they suffer an illness. Third, it proposes a set of actions to be carried out.

The guide has three sections. The first section consists of a summary of the current legislation. The second consists of a set of records presenting in a brief manner the main characteristics and requests of each religion which might arise in a hospital. The final section seeks to suggest actions to be adopted based on existing best practices.

### 12.3. Plan director de inmigración (Immigration Master Plan)

This is a specific planning tool from the Health Department aimed at establishing guidelines for the delivery of healthcare to the foreign immigrant population living in Catalonia, in the overall context of the actions of the Generalitat. It includes the participation of immigrant entities and associations, takes into account the objectives and interventions of Catalonia's Health Plan and it defines the health strategies addressed to this population in particular.

The principles and values that support the *Plan director de inmigración* can be summarized as follows:

- The citizen is at the heart of attention/healthcare.
- The healthcare provided must be comprehensive, universal, coordinated, multidisciplinary, accessible, and supported with effective and sustainable actions.
- Healthcare must be provided by competent professionals.

### 12.4. Education and information actions

From an institutional point of view, the healthcare administration should seek to:

- Develop strategies aimed at raising professionals' and healthcare institutions' awareness of the principles set forth in the Charter of citizens' rights and duties regarding health and healthcare, of other programmatic declarations - this document included - and of the Patient's Autonomy Law 21/2000, especially the articles related to equality and non-discrimination. For this reason, all information and education actions which may encourage, according to these laws' objective, respectful healthcare are to be optimized, beyond merely bureaucratic aspects.
- Regular and repeated education and information actions should be a priority for the health administration, with the tender of the entities which provide services.
- For healthcare provided to citizens with a different language or cultural code which may result, for others, in misunderstandings, errors or distrust, it is advisable to encourage the use of an intercultural communicator and favor his/her presence in the healthcare system.
- Concerning the most vulnerable groups, it is necessary to make sure that they do not become passive objects of biomedical research.

#### 12.5. Assessment actions

Gathering comprehensive knowledge of reality and of the relationships between patients and professionals involves carrying out an *assessment plan* of behaviors and practices which shows the extent to which health-related rights are respected. In many cases, we only have to incorporate these evaluations from the Catalan Health Service into already-existing procedures, such as the evaluation of complaints and suggestions and assessment of the accreditation processes or sanitary inspection.

Given the diversity of the problem and the characteristics of the centers, in many cases, the creation of ad hoc assessment procedures will be necessary.

### 13. FINAL RECOMMENDATIONS

1. The healthcare system should aim to achieve a degree of cultural competence that ensures fair, high-quality healthcare for all users, irrespective of their cultural, religious or ethnic origin.
2. Fair and high-quality healthcare begins with a good reception, guiding the user and providing them with adequate information. Since language may often be a considerable obstacle, appropriate organization and distribution of intercultural communicators is required in order to meet existing needs.
3. Institutions shall make it possible for healthcare professionals to know the reasons for consultation of users pertaining to different cultural groups as soon as they can (urgency depends on the potential severity of the health problem). The role of interpreters or intercultural communicators is especially emphasized from the outset of the medical appointment.
4. The presence of multiculturalism in society should be reflected in the incorporation of new professionals at all levels of the healthcare system.
5. The role of intercultural communicators is to be recognized within its relevant limits; they cannot be expected to assume responsibilities beyond their scope. Their job description and systematic inclusion in the healthcare teams who need them are initiatives that the administration has to address urgently.
6. Healthcare professionals shall be provided with ongoing information about healthcare for people from different cultures. Each center will organize courses so that staff can learn about the cultural characteristics of the diverse ethnic groups of the area and can, consequently, become culturally-competent healthcare professionals.
7. It is necessary to establish links between the healthcare administration (CAP, hospitals, pharmacies, management bodies) and the diverse ethnic and cultural groups of the healthcare area in order to become familiar with the healthcare needs of these groups appropriately. The various departments or services should have professional experts specializing in the kind of healthcare needed.
8. It is important to foster ethical discussions in all the spheres the healthcare system already encompasses (healthcare ethics committees), in order to face

the new and diverse situations arising from the delivery of healthcare to people with different cultural values and ideas regarding their own health and life.

9. We should promote community health by means of educational activities within the specific groups.
10. Centers' management bodies are to be aware of new situations and act in a realistic manner so that professionals can duly perform their job. Proper time distribution and incorporation of the different multicultural and multidisciplinary professionals into the teams are fundamental conditions for maintaining high-quality healthcare.
11. The planning of activities at each center should adapt to the characteristics of the community, as well as to solving the main disagreements and conflicts that are likely to arise and which might be foreseen.
12. Assessment mechanisms are to include the tools needed for identifying the problems seen in everyday healthcare provided to people from different cultures.
13. Culturally-sensitive research will be conducted in order to obtain accurate information about the realities of these groups.
14. Institutions and professionals will make sure that research protocols are strict enough, that methods for inclusion of people belonging to vulnerable minorities are respected and that inclusion/exclusion criteria are not discriminatory.
15. Patients' manifestations will be given a kind, honorable and sensitive treatment, specific to their culture, and special deference will be shown regarding their illness as well as during the moments of birth and death.

## 14. GLOSSARY

- Acculturation:** Cultural transformation caused by the reception and assimilation of the elements of one human group by another.
- Acculturative stress:** The effort a person must make in order to adapt to new cultural conditions.
- Cultural awareness:** Recognition that culture plays an important role in each interaction, that it affects each participant and that it is the professional's responsibility to assume this role when they are required to.
- Cultural competence:** Ability to communicate with people from different cultures, irrespective of their culture of origin. In the case of the healthcare system and its professionals, the aim is to improve health outcomes and achieve greater satisfaction among users and professionals. Cultural competence allows healthcare professionals to develop a respect for and be sensitive to the values, beliefs, ways of life, practices and problem-solving strategies existing between their culture and that of their patients. This involves continuous research and reflection about the professional's own cultural history.
- Culture:** Set of distinctive spiritual and material, intellectual and affective aspects characteristic of a society or a social group and which comprises people's ways of life, the way in which they live together, value systems, traditions and beliefs (World Conference on Cultural Policies. Mexico, 1982; Intergovernmental Conference on Cultural Policies for Development. Stockholm, 1998).
- Community/individualistic cultures:** In a community culture, the groups' objectives are valued over those of the individual. Great value is lent to upholding long-term good relationships between the members of the group, while maintaining statuses and hierarchies. In an individualistic culture the opposite is true: individual objectives take precedence over the group's objectives and each person's freedom and individual rights establish the statutory structure which defines ways of life.
- Cultural group:** A group of people sharing some cultural standards which identify them.
- Cultural imposition:** Imposing one's beliefs and patterns of behavior on other people. In the healthcare setting, this relates to imposing such beliefs on the patient.

**Discrimination:** Treating people unfairly due to their ethnic origin, racial group, religion, age and many other personal and socio-cultural factors.

**Ethical universalism:** Different ethical trends consider that there are universal ethical principles based on the rationality characteristic of mankind as a whole. These principles are above cultural peculiarities.

**Ethnocentrism:** A mindset that is present among many people who consider other cultures to be inferior to their culture. There are different degrees of ethnocentrism, and people who live and think of their cultural values as being universal and absolute are sometimes unaware of this, even though reality shows their assumption to be false. When ethnocentrism reaches an extreme degree it leads to xenophobia, which is the rejection, sometimes even violent, of anything which is alien, foreign or different.

**Ethnorelativism or cultural relativism:** Considers that all cultures are justified by their context.

**Female genital mutilation:** General name used to refer to practices involving total or partial removal of female external genitals or other aggressive practices to women's genital organs with non-therapeutic aims, due to cultural or religious reasons or reasons of any other nature.

**High-context culture:** In this type of culture, meaning is mostly found in the situation where communication takes place or in the relationships maintained between the communicators, rather than in words used. High-context cultures are extremely courteous and indirect.

**Immigrant:** An immigrant is a person who arrives in a country where he or she was not born in order to settle there. This intention to settle may be either temporary or permanent and does not imply that the person has a residence permit. Immigrants are not merely people who come from poor countries.

**Intercultural communicator:** A professional with knowledge and skills of cultural competence who facilitates relationships between people from different cultures in the healthcare setting.

**Low-context culture:** In this type of culture, messages are direct, explicit and their meaning does not depend on context. The concern to be clear is more important than establishing what the other person's feelings are. In a low-context culture, conversations deal directly with the topics to be addressed, leaving aside emotional or sensitive issues.

**Perceived discrimination:** Subjective perception of being discriminated on ethical, racial or religious grounds or due to other reasons of a personal or socio-cultural nature.

**Racism:** Set of beliefs, ideologies and social processes involving discrimination against people because they apparently belong to a social group.



## 14. GLOSSARY

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**Tolerance:** Willingness to accept other people's way of thinking, acting or behaving, which is different to ours. Respect for opinions and behavior which may seem strange to us.

**Vulnerability:** Situation of a person or group characterized by a serious risk of sustaining damage to their survival or their life (biological, psychological or moral).

**Xenophobia:** Hate toward, resentment of or contempt for foreign people.

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This report was approved at the 60<sup>th</sup> Plenary Meeting of the Catalonia's Bioethics Advisory Committee, on June 19<sup>th</sup>, 2007.

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