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SPECIAL ISSUE

INTERCULTURALISM
A COMPARATIVE LEXICON
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Intercultural Health

Abstract
This contribution investigates the meaning of 'intercultural health' through an analysis of the contexts in which this definition emerges. In particular, three areas are analyzed: that of indigenous communities, that of migrants and refugees and the more general context of therapeutic choices determined by cultural values. A final part of the article is aimed at analyzing the legal tools that foster the intercultural dimension of health, intersecting with the three different fields examined.

Keywords: Intercultural, Health, Law, Difference, Comparative Law.

1. What is intercultural health?

What is intercultural health? The answer to this question is typical of legal language: it depends.
It depends first of all on the meaning given to the parts of this definition, i.e., 'intercultural' and 'health'. If on 'health' there is some convergence, for example considering the broad definition provided by the World Health Organization, which defines it as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", the term 'intercultural' brings with it a number of questions and the need for further investigation[1].
It is a cause for complexity: the definition of interculturality, in fact, depends on the meaning attributed to the terms 'culture' and the suffix 'inter'. Culture crosses various disciplinary domains – such as

[1] See the Preamble to the WHO Constitution, adopted in New York in 1946, entered into force on 7 April 1948: «Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity» (available at https://apps.who.int/).

anthropology, sociology, etc. – which do not necessarily converge towards an unambiguous definition and, even when adopting a purely legal perspective, still ambiguities remain.

The suffix inter-, for its part, necessarily confronts the concept of multi-culturalism. The transition from multiculturalism to interculturalism has been the subject of numerous debates and is the focus of extensive literature.

It is difficult to draw a precise line to distinguish the two concepts, both of which relate to cultural plurality and cultural pluralism: their main difference seems in fact to manifest itself in the relationship between the one (plurality) and the other (pluralism). In particular, interculturalism seems to be entrusted with the management of coexistence, on which multiculturalism would have been deficient, giving voice to the enhancement of plurality (a social fact) through pluralism (more a value, than a fact). The concept of interculturalism is often 'called upon' to remedy the divisions that multiculturalism allegedly fomented, being more aimed at dialogue than the latter, and promoting a sense of *vivre ensemble,* more than coexistence in society. The defects and merits of both concepts, however, are the subject of much debate[2].

This is not the place to analyze the different positions in this regard and, moreover, one fact can be taken as a starting point: interculturalism is part of the legal language and connotes different definitions. Health is no exception.

Building on this starting point, this paper will explore areas in which the right to health is considered from an intercultural perspective. The meaning of this definition in different areas will be explored, looking for commonalities and divergences, both in the legal sources and literature and through the analysis of tools addressing intercultural issues in health.

2. Where do we find intercultural health?

Looking at the legal literature and sources of law in the comparative sphere, one can see that intercultural health is mentioned mainly in three areas.

First, numerous references emerge with regard to indigenous communities. This first area of relevance is thus based on certain assumptions: that these communities exist in a given territory, that they are recognized, and that specific policies are adopted to promote the intercultural dimension of health.

In this regard, numerous examples emerge in the South American context. The intercultural dimension of health (often with reference to indigenous communities) is mentioned in Constitutions[3],

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[2] Among the others: Taylor (2012: 413 ff.), Parekh (2000), Barrett (2013), Cantle (2012), Kymlicka (2010) and the Council of Europe's *White Paper On Intercultural Dialogue* (CM(2008)30).

[3] See for example art. 18 of the Bolivian Constitution: «Todas las personas tienen derecho a la salud. (…) El sistema único de salud será universal, gratuito, equitativo, intracultural, intercultural, participativo, con calidad, calidez y control social. . (…)» (available at https://bolivia.justia.com/nacionales/nueva-constitucion-politica-del-estado/); or art. 32 of the Constitution of Ecuador: «La salud es un derecho que garantiza el Estado, cuya realización se vincula al ejercicio de otros derechos, entre ellos el derecho al agua, la alimentación, la educación, la cultura física, el trabajo, la seguridad social, los ambientes sanos y otros que sustentan el buen vivir. (…) La prestación de los servicios de salud se regirá por los principios de equidad, universalidad, solidaridad, interculturalidad, calidad, eficiencia, eficacia, precaución y bioética, con enfoque de género y generacional» (available at https://www.salud.gob.ec/base-legal/).

in legislation, in specific programs contained in government actions, or adopted by professional bodies and government agencies[4]. Interculturality is mentioned in guidelines, policies and best practices in the different areas of human health, and programs are aimed at providing the training to ensure that professionals possess intercultural skills[5]. The reference to the intercultural dimension of health and its importance is recurrent in some areas. In particular, for example, its importance appears to be considered in the context of maternal and child health and, in a broader perspective, in the area of human reproduction[6].

Of course, assessments of the success and effectiveness of these actions and programs cannot be separated from a broader consideration of the issues at stake. The inclusive dimension of health, in fact, is to be considered in the light of the effectiveness of the right itself; it is therefore important, first and foremost, that the socio-economic and political conditions necessary to guarantee the right to health are ensured in the contexts in which these communities are considered.

Put simply: the communities in question must exist on a territory, they must 'be seen' by legal and political systems, and these should then converge in their willingness to adopt policies and actions aimed at inclusion. Interculturality in other words, in health as in other spheres, is a tool that depends upon a number of preconditions. Seen from this perspective, in this first area the concept of interculturality is part of a broader framework, where the protection of the cultural dimension appears as one of the determinants of health.

A second area where the recurring reference to the intercultural dimension of health emerges is that of migratory phenomena: the need for intercultural competences appears with particular reference to migrants and refugees.

This second sphere is of particular interest because it offers the opportunity to investigate the breadth of the concept of culture in its intersections with the legal protection of health. For example, it makes evident that an essential prerequisite of any cultural relevance in healthcare is the possibility of mutual understanding. It is therefore not surprising that the first reference encountered in the context of the intercultural skills of health workers is to the linguistic dimension[7].

However, the 'understanding' at stake in relation to the health of refugees and migrants also refers to a deeper horizon of meaning, of which the linguistic aspects are only a first part.

With reference to health, the concepts of culture and intercultural dialogue take on different meanings. Linguistic diversity is only one of the possible obstacles to understanding the needs underlying the words (or even the silences) of people from different backgrounds. Indeed, on closer inspection, language is perhaps the most solvable problem. The attribution of meaning to choices in the sphere of health, instead, can be complex even when caregiver and patient come from the same

[4] Ruiz Cervantes (2013).

[5] See for example the programs mentioned by the website of the *Pan American Health Organization*, (https://www.paho.org/en/topics/cultural-diversity-and-health). See also J. Mignone *et al.* (2007).

[6] See for example the intercultural health initiatives by the *Fundacion de Waal* (available ar https://fundaciondewaal.org/index.php/2021/12/27/safci-policy-a-culture-of-prevention-in-bolivia/?lang=en). See also, among the others, van Dijk, Ruiz, Letona, García (2013: 365-82); Llamas, Mayhew (2018: 686); Matute, Martinez, Donadi, (2021: 14-19).

[7] Kahr-Gottlieb, Papst (2013); World Health Organization (2020). See also the *Second National Intercultural Health Strategy 2018-2023*, adopted by the Irish Health Service Executive (available at https://www.hse.ie/eng/about/who/primarycare/socialinclusion/intercultural-health/intercultural-health-strategy.pdf).

geo-cultural background. What lies behind the refusal of therapy? How much does one's own personal conception of life influence the decision to undergo (or not) surgical treatment?

Cultural aspects often play an important role in choices concerning the body and health: understanding these aspects becomes even more complex when cultural assumptions are made by caregivers and patients of different cultures.

In these cases, the lack of comprehension is determined by the misunderstanding of acts and choices, which take on completely different meanings depending on their cultural assumptions. Again, words and silences can be misunderstood, generating communication stalemates.

Of course, also in this second area, socio-economic conditions are relevant and compete with culture as determinants of health: the one (culture) without the others (socio-economic conditions) is not sufficient to guarantee the right in question.

That said, intercultural competencies appear in the training of health personnel and become part of the knowledge required at the professional level[8]. These competences refer to different levels, starting with the linguistic one, which enables the first step of any communication: mutual understanding.

This need for understanding, however, also lies at a deeper level, where it is not so much a question of understanding words and different languages, but rather of attributing meaning to them. This is a complex operation, which can come up against the unspoken and, above all, possible misunderstandings of identical behaviors, to which individuals attribute different, if not opposite, significance. The meaning of illness and its consequences on the body may vary from person to person, depending also on the cultural meaning they hold. Consequently, the words used to describe one's illness change, as do the words used to indicate the methods of treatment[9].

In these cases, misunderstandings do not arise only from the different words used to voice one's discomfort. One of the most difficult aspects of communication arises from the difficulty of attributing meanings to words that do not belong to different languages, but rather are identical in form but not in content. While it can clearly be difficult to understand the role of a word that does not exist in one's own language in the description of illness (for example the Islamic *Jinn*[10]) if one is unfamiliar with this concept, even greater difficulties can be encountered when the word for a given 'illness' is used to indicate ailments other than those attributed to this meaning.

There are several examples in this respect: the field literature gives ample evidence of this, analyzing the words that express well-being and malaise in relation to different cultures and in relation to diagnosis and treatment. Among many studies we can mention the cases recounted by Mario Ricca and Ivo Quaranta, in which they describe many examples of misunderstanding based on different cultural assumptions by patients and healthcare professionals[11].

One might ask what the legal relevance of these aspects might be: they are all of great interest, but presumably closer to sociological or anthropological disciplines[12]. On the contrary, these aspects are of primary importance also from the legal point of view, because they can affect the fundamental

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[8] Verrept (2019); Napier *et al.* (2014: 1607 ff.).

[9] Ricca (2022); Spieldenner, Toyosaki (2020).

[10] Böttcher, Krawietz (2021). See also Ejaz Ahmad's (journalist and cultural mediator) interview concerning the importance of culture and, in particular, of ethnopsichiatry (15 March 2018, available at https://www.sanitainformazione.it/lavoro/paziente-immigrati-differenze-culturali/)

[11] Quaranta, Ricca (2012: 13 ff).

[12] The same question could be asked in relation to the topic of interculturalism: Bagni (2019).

principle of the relationship between caregiver and patient: informed consent. Created to guarantee both the freedom and the moral dimension of the therapeutic choice, which is undoubtedly an expression of identity, informed consent presupposes first and foremost a mutual understanding between caregiver and patient[13]. It is in fact a tool that serves to bridge the asymmetry of knowledge that characterizes the two figures of doctor and patient. The expression of valid consent, however, presupposes a full understanding of the information provided. The lack of sharing of the (often unexpressed) cultural paradigms of health and care concepts can lead to misunderstanding. In this sense, one understands the numerous references to the intercultural preparation of health workers, which is mainly aimed at communication and understanding the profound needs that the interlocutor is not always able to express.

The meaning of the adjective 'intercultural' emerges, which can be summarized as the ability to put oneself in the shoes of others, to be able to understand the meaning to be attributed to behavior so as not to misunderstand or ignore it.

This ability can also be useful in the legal sphere, where understanding the precise definition of concepts in the culture of the person in front of us does not appear so important. Rather, it appears important to place certain choices in the value scale of the person making them, and thus of the role played in his/her life, as an expression of fundamental values.

Different choices, in different contents, may be the expression of similar values: the importance of the family/community, respect for childhood, fear of illness or death. These are concepts which can be best understood when looking at the place they occupy in people's lives, rather than at their content.

This seems to be an important aspect of interculturality, also in a more general perspective, not necessarily referring to health alone. Beyond just understanding a definition of cultural behavior that is difficult to grasp for those who do not belong to that culture, it seems to be relevant to understand the values expressed by that behavior and the place that those values occupy in the person's life. It is, in other words, the ability to feel a sort of 'resonance' of something that manages to sound familiar to us not because of the content of a particular choice, which we may not even understand, but because of the importance it occupies in a person's scale of values, which we can understand.

This can apply to various aspects, from lifestyle or daily life habits, that differ from the surrounding context (e.g., eating habits, clothing or the choice of days of rest), to the life-and-death issues that can arise in the area of health. For example, the choice to refuse a certain therapeutic treatment does not necessarily need to be understood in the light of the religious scriptures that motivate it, but rather in the light of the value that it takes on in the person's life: for example in the light of the price that must be paid (e.g., loss of eternal life, or exclusion from the community to which one belongs). Analyzing the role that such a choice plays in a person's life does not mean ascribing a certain consequence, nor does it mean that one will automatically fall into one or the other freedom. In fact, law and freedom intertwined in the field of healthcare form a complex picture, which depends on many factors that have been analyzed and constructed over time, primarily by the jurisprudence of the courts.

These considerations lead to the third area of relevance of the concept of intercultural health, in which culture takes on a meaning of *Weltanschauung*, not necessarily related to belonging or origins, thus concerning the cultural determinants of therapeutic (or, more generally, health-related) choices

[13] The literature about informed consent is enormous, see the seminal: Faden, Beauchamp (1986).

irrespective of group, minority or geo-cultural backgrounds. In this regard, it is possible to cite as an example the therapeutic choice of ‘alternative’ methods (other than treatments provided by health services). For example, cancer treatments that are not based on scientific principles are a recurring theme legal systems must confront, with respect to the protection of individual freedom within health systems. In this regard, similar events have occurred at different times and in different countries, if in recurring ways: from the ‘Laetrile case’ in the United States of America (during the ‘60s-’70s[14]), to the Italian cases (from the ‘Bonifacio’[15] and ‘Di Bella’[16] cures, during the ‘60s and ‘90s, to the more recent ‘Stamina case’[17]), to the contemporary issue of the ‘*pilula do cancer*’ in Brazil[18].

Cultural identity is only one of the issues at stake, as these events also deal with individual freedom, especially when ‘alternative’ therapeutic choices involve minors (as particularly in the last of the Italian cases cited: ‘Stamina’). However, even alternative treatment choices can raise cultural issues, as can also be seen with reference to the possible legal instruments adopted to manage them (see below).

3. Legal tools

An analysis of the tools that legal systems provide in the area of intercultural aspects of health allows for a better understanding of this concept.

Certainly, all the policies and training actions already mentioned, with particular reference to the health of indigenous communities, are useful for addressing interculturality in the field of health: they can fall under the definition of ‘intercultural tools’.

From a more general perspective, definitions can also be important in this regard. The definition of methods of treatment on the one hand as ‘official’ or, on the other hand, as ‘alternative’ or ‘complementary’, for example, can delineate the relationship between different conceptions of care and their place in healthcare systems[19].

From this perspective, definitions can also be an expression of the search for legal instruments of interculturality in the field of health. For example, the concept of ‘integrative health’ is particularly relevant: it is used to combine conventional and complementary medicine, according to a holistic vision of care and the person[20]. Similarly, the definition of ‘intercultural health’ has emerged in doctrine with reference to some South American indigenous communities, in which interculturality implies the ‘complementarity’ of both medical conceptions involved: ‘practices in health care that bridge indigenous medicine and western medicine, where both are considered as complementary’[21] .

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[14] Greenberg (1980: 799-807).

[15] The explanation of the *Bonifacio Anticancer Goat Serum* is available at https://acsjournals.onlinelibrary.wiley.com/doi/pdf/10.3322/canjclin.21.1.43.

[16] Traversa (1999: 1903-1911).

[17] Solarino, Laforgia, Dell’Erba, Laforgia (2015). See also the article *When right beats might*, in *Nature*, 2015, 518, 455, in *Front Cell Neurosci.*, 2015; 9: 240.

[18] Pandolfo, Teixeira Lino, Mundstock Xavier De Carvalhoo (2020); Pirhofer, Bükki, Vaismoradi *et al.* (2022).

[19] WHO (2013); Stepan (1985).

[20] See the report by the National Institutes of Health National Center for Complementary and Alternative Medicine, *Complementary, Alternative, or Integrative Health: What’s In a Name?*, October 2008 (adj. 2013): «Integrative health brings conventional and complementary approaches together in a coordinated way».

[21] Mignone (above, at note 5).

In addition to these specific definitions, there is also the concept of 'cultural humility', which is evoked in the literature to indicate the construction of a therapeutic relationship that is not based – to the extent possible – on an 'us-them' divide, with particular reference to stereotyping and prejudice regarding the affiliations of the persons involved in the treatment decisions[22]. Interculturality, according to this perspective, requires avoiding the stigmatization of the interlocutors in the therapeutic relationship, especially with regard to choices, which are expression of a 'normative belief system' different from one's own: a principle that sounds familiar to those who deal with legal comparison and interculturality. A not dissimilar concept has been evoked with reference to the definition of 'cross-cultural medicine', which emphasizes the importance of being aware of the cultural assumptions that determine the therapeutic choices of all the interlocutors involved[23].

It is not easy to understand whether and to what extent these definitions can be applied to the various areas in which culture and health intersect, embracing the various identities, in the very different contexts in which they are expressed.

However, these definitions take into account a typical aspect of interculturality: the search for channels of communication and ways of living together that go beyond mere coexistence. On closer inspection, despite the variety of meanings, this appears to be a common trait of intercultural approaches, especially in relation to the concept of multiculturalism. If the latter, rightly or wrongly, had been accused of having contributed to building islands while forgetting bridges, it is precisely in order to build bridges that, in the opinion of many, the concept of interculturality has intervened.

As already mentioned, this is not the place to explore the debates on the 'fall' of the concept of multiculturalism and the subsequent role of interculturalism in different fields and disciplines.

However, various instruments appear to ensure the coexistence of different cultural paradigms also in the field of health, regardless of the affiliations and belonging within social groups.

One example is the "Terni Declaration" adopted by the FNOMCeO (the National Federation of the Councils of Physicians, Surgeons and Dentists in Italy) in June 2002, which took note of the diffusion of certain 'unconventional medicines and practices' and defined their practice as 'a medical act', therefore reserved exclusively to the professional figure of licensed doctors[24].

This document has been the subject of various, even conflicting, interpretations: a sort of validation of therapies not based on scientific criteria, according to some, a necessary tool according to others. On the one hand, in fact, the day after its approval, 35 scientists (including Nobel Prize winners Renato Dulbecco and Rita Levi Montalcini) published an open letter in which they expressed their bitterness about an act that could be read as an acknowledgement of the 'presumed therapeutic efficacy of so-called non-conventional remedies not (...) proven by the application of rigorous scientific procedures'. On the other hand, the same document has been interpreted as an acknowledgement of

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[22] Lekas, Pahl, Fuller (2020).

[23] Carey Jackson J. defines cross-cultural as follows: «(...) cross-cultural medicine is not a specialty or an exotic addition to "normal" medicine. Cross-cultural medicine is simply recognizing that the history-taking and treatment plans of medical practice and the organizational structure in which it is practiced is "situated" socially and culturally, and that position is often one of privilege for the clinician and the system that trains clinical staff and contextualizes clinical medicine» (available at https://ethnomed.org/cross-cultural-medicine/, 19 February 2020).

[24] The document adopted by the FNOMCeO (*Linee guida della Federazione Nazionale degli Ordini dei Medici Chirurghi e degli Odontoiatri su medicine e pratiche non convenzionali*, Terni 18 May 2002) mentions as 'unconventional medicines and practices': acupuncture, phytotherapy, ayurvedic medicine, anthroposophical medicine, homeopathic medicine, traditional Chinese medicine, homotoxicology, osteopathy, chiropractic.

the diffusion of certain therapies (both among caregivers and care recipients) and the consequent need to search for a discipline that allows for their coexistence, according to the modalities that best guarantee the protection of health (supervision by a doctor)[25]. Both positions highlight the symbolic relevance of these statements, which are expressions of different paradigms of care.

Similar acknowledgements also appear in statutes and in case-law. The Italian Court of Cassation, for example, in 2012 recognized (in an *obiter dictum*) the role of the *mohel* as a possible meeting point between the need to protect the health of male infants and the exercise of religious freedom[26].

Even specific pieces of legislation, such as the New Jersey *Declaration of Death Act* (1991) or the Japanese *Organ Transplantation Act* (1997), allow (under certain conditions) a choice between the cardiac and cerebral criteria when defining a person's death[27]. The reason for these different possible definitions is cultural, as in both cases they are irreversible clinical conditions whose significance depends on religious or, in a broader sense, personal beliefs.

The relevance of cultural aspects often emerges in the context of the end of life. The way the inanimate body is handled in care facilities, for example, depends on the identification of spaces, places and procedures that reconcile hygienic and sanitary needs with the rituals surrounding the inanimate body in different cultures or religions[28].

Such arrangements are sometimes explicitly recognized in documents and best practices but, in the absence of specific research on this topic, they are sometimes difficult to identify. For this reason, literature and sometimes the news can also be sources where the tools of interculturality can be found. It is precisely in such instruments and documents, then, that we sometimes find reference to the law, which is to be seen as a last resort.

A clear example of this can be found in the issue of the rejection of caesarean sections in the presence of a dangerous situation for the mother, the unborn child or both. The cultural relevance of this topic stems from the basis of rejection, which is often linked to religious or cultural motives. The complexity of the interests at stake – the mother's self-determination, the unborn child's right to life and health, the position of health personnel – are combined with the complexity of coercive treatment, which is even more problematic in the case of the woman giving birth. The literature on the subject testifies to the search for paths of dialogue that are able to steer the mother's choice in a direction that is favorable to the health of the unborn child. In this sense, for example, the recommendations issued by some North American scientific societies emphasize a series of passages in which cultural understanding appears to be the predominant element, alongside the preference for recourse to ethics committees instead of judicial intervention, which is seen as a last resort[29].

Apart from this last specific example, which presents some peculiarities in that it involves a third subject (the unborn child), even in this third area of operation the cases reported attest to the relevance of an old instrument (informed consent) in a new field (intercultural health). Informed consent emerges

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[25] The open letter is available at the website https://www.cicap.org/n/articolo.php?id=271808 (Cicap, *Nobel contro medicina non convenzionale. Dulbecco e Montalcini firmano documento con altri 35 scienziati*).
[26] See the decision of the Italian court of cassation n. 43646, 22 June 2011 (available at https://archiviodpc.dirittopenaleuomo.org/, in Italian).
[27] Casonato (2023: 130 ff).
[28] Ferrero, Pulice (2021).
[29] Sontag (2017).
[29] See for example the policies recalled in *Patient choice: maternal-fetal conflict. Committee on Ethics. The American College of Obstetricians and Gynecologists*, in *Womens Health Issues*, 1, 1990, p. 13 ss. See also Deshpande, Oxford (2012: 144).

as the basic principle of the intercultural dialogue, as it stipulates that no therapeutic action can take place without the individual's consent, not even if it is aimed at guaranteeing the patient's own life. In fact, the individual is entrusted with identifying his/her own 'good', which corresponds to his/her own values, his/her own feelings, the way he/she considers his/her own body and personality. A 'good' that represents a personal dimension, of which the biomedical aspect is only a part. Such a horizon of meaning may be different for each person, depending on their desires, experiences, and projections of self-image in the future. Depending, in other words, on one's own culture.

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