From patient healthcare to global health: Interculturality in the medical field

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Abstract (English)

Exhaustively understanding the concept of health and how interculturality forms a part in it requires the distinct perception of its multifaceted and utterly complex playgrounds. Different conceptions of health and their potential underlying interculturality and implications can range from classic patient-doctor relations to the sphere of international and global health. While a linkage of intercultural counseling in the realm of health theoretically does exist when it comes to patient healthcare, it still seems limited and in its infancy. Hence, within topics such as the so-called migrant medicine and culturally sensitive patient care, the question whether the health sector in its work ethos will move beyond knowledge and assumption building on essentialist and positivist understandings of culture is debatable. Nevertheless, the conception of health can also transcend literal borders and be conceptualised as Global Health in exemplary form of humanitarian aid or the endeavour of combating diseases of global concern such as the COVID-19 pandemic. Here, potential re-thinking approaches by using knowledge from postcolonial theories can be seen and a current joint call to decolonise global health can be made evident. The article seeks to fathom this call and exemplify why despite these initial approaches, there is still a huge discrepancy between theoretical knowledge and practical application of it.

Keywords: Global Health, International Health, Doctor-Patient Communication, Humanitarian Aid, COVID-19 Pandemic, Post-Colonialism, Decolonizing

Abstract (Deutsch)

Ein umfassendes Verständnis des Begriffs der Gesundheit und der Rolle der Interkulturalität in diesem Begriff erfordert eine differenzierte Wahrnehmung seiner vielfältigen und äußerst komplexen Spielwiesen. Unterschiedliche Konzeptionen von Gesundheit und die ihnen möglicherweise zugrundeliegende Interkulturalität und ihre Implikationen können von der klassischen Patient-Arzt-Beziehung bis hin zum Bereich der internationalen und globalen Gesundheit reichen. Zwar gibt es theoretisch ein Zusammentreffen interkultureller Beratung im Bereich der Gesundheit, wenn es um die Gesundheitsversorgung von Patienten geht, doch scheint dieses bisher noch begrenzt und in den Kinderschuhen zu stecken. So ist es bei Themen wie der so genannten Migrantenmedizin und der kultursensiblen Patientenversorgung fraglich, ob der Gesundheitssektor in seinem Ethos über das Wissen und die Annahmen hinausgeht, die auf einem essentialistischen und positivistischen Verständnis von Kultur beruhen. Nichtsdestotrotz kann das Konzept der Gesundheit auch buchstäbliche Grenzen überschreiten und als Globale Gesundheit konzeptualisiert werden, wie etwa in der humanitären Hilfe oder bei der Bekämpfung von global bedeutsamen Krankheiten wie der COVID-19 Pandemie. Hier können potenzielle Denkansätze aus postkolonialen Theorien gesehen werden und ein aktueller gemeinsamer Aufruf zur Dekolonisierung der globalen Gesundheit ist ersichtlich. Der vorliegende Artikel versucht daher, diesen Aufruf zu ergründen und aufzuzeigen, weshalb trotz dieser initialen Ansätze noch eine große Diskrepanz zwischen theoretischem Wissen und dessen praktischer Anwendung besteht.

Schlagworte: Globale Gesundheit, Internationale Gesundheit, Arzt-Patienten-Kommunikation, Humanitäre Hilfe, COVID-19-Pandemie, Postkolonialismus, Decolonizing

1. Introduction

The multifaceted field of medicine and health presents an ideal environment for healthcare professionals to engage in client-centered work and counseling practices, with a particular focus on intercultural competence. As a somewhat prototype for this field of work, medicine always involves a dynamic relationship between professionals and non-professionals, typically patients in its most prominent example. In addition, the intricate nature of cultural competence – and what that means for the health sector – as well as its interplay with interculturality across diverse healthcare settings remains an ongoing area of research. This requiresfurther theoretical exploration to advance our understanding of this complex phenomenon. The present article aims to provide a glimpse into two distinct arenas of the health domain, namely the clinical setting and the overarching concept of global health, and to explore how interculturality is perceived and how counseling practices are based on certain understandings. Furthermore, the article endeavours to critically examine the current status quo in these playgrounds of health and to provoke discussion on the findings. The ultimate objective is to contribute to the ongoing discourse in these fields through theoretical exploration and discussion.

At first glance, the concept of health seems to have something in store that the concept of culture seems to lack: a clear and therefore satisfactory definition. Culture as a term with all its facets could mean many things, yetwhen it comes to health, usually people havea clear sense on what being healthy connotes or what constitutes such a state. However, on a second glance the conceptof health entails more than the sheer absence of disease or infirmity as according to the World Health Organisation it incorporates "a state of complete physical, mental and social well-being" (WHO 2020:1). Undoubtedly, those who have embarked on the endeavourto explore the complex relationship between health and interculturality as to identify their interdependent dynamics have probably

not done themselves any favor by doing so. Not only being hopelessly vague, the definition of health as such simultaneously entails a mere impossibility to ever being achieved. In other words: we either need to acknowledge the fact that health is reserved to only ahandful of lucky human beings on thisplanet or thatitis only a brief moment in time for some and an unattainable asset to the most – and will still struggle to come to terms with health beyond its biophysical explanation. To what extent is health a political and power-related momentum? Does culture influence health and vice-versa and how much does our environment and cultural upbringing determine how we communicate and think about health?

While books could be filled with each one of these questions, the article at hand seeks to discuss and shed light on the intricate endeavour of bridging the notion of intercultural communicationor interculturality as suchwith the multi-faceted field of health. Inherently it also asksif and how this field makes use of intercultural researchas well asknowledge on interculturality at all. In aiming at offering an initial overview at most withoutthe deserved depths of eachrespective distinct subject matter, the article elaborates on two different understandings and playgrounds of health and its potential underlying interculturality and implications ranging from classic consultancy notions in patient-doctor relations to the sphere of global health. Hence, the article tries to fathom clear goals from successful healthcare and what that means consequently in this field to the humble ambition of achieving global justice in form of emerging discoursesof decolonising the global health system. However, it should be noted that the article only touches on certain aspects and examples, rather than presenting an exhaustive analysis. The objective of this isto shed light on the statusand discuss itslinkedproblematics.

With this, the intention is tocontribute to the broad and ongoing discourse in this field rather than offering alternative solutions or potential synergies with other fields.

When examining interculturality in the health sector, it is crucial to be attentive in distinguishing the particular field under consideration. When we look at interculturality in the broad field of healthcare or medicine, what we often find is a proclaimed need for 'more cultural competence' and this can be analysed in many facets. Nevertheless, the terms are often deemed interchangeable. This phenomenon may stem from the overarching objective within patient healthcare to understand cultural groups in a targeted manner, as elucidated in the present article. So-called cultural competence can interplay on macro, meso and micro levels, by which macro would reflect the societal level, meso the organisational aswell as structural one and micro the individual clinical level (Handtke 2019). The article in its first half will primarily only focus on the latter before diving into the notion of global health and the accompanied claim to decolonise its inherent system. However, to provide a broad overview of the vast complexity intercultural research within patient healthcare can reveal: on a societal level these different play-grounds of interculturality can look for instance at general availability and access to healthcare of different cultural groups – as cautious as these distinctions are to be handled. Moreover andexemplary on a meso level there is potential to assess the degree to which the population's cultural and linguistic diversity is represented in healthcare organisations for example among other aspects (Handtke 2019, Betancourt 2006). At an individual level, we can observe numerous interpersonal dynamics within a clinical hospital environment. However, this article will mainly focus on the patient healthcare provider relationship as it's the most prominent example for health counseling. Consultation offers and coachings in the medical field have been concentrating

on this encounter aiming to provide 'intercultural knowledge' to care providers. Therefore, in this article's first part, we seek to discuss various intercultural aspects and their implications before diving into global health discussions.

2. Interculturality in the clinical field

2.1. The (culturally competent) good doctor

What is the significance of incorporating knowledge of interculturality for medical practitioners and other healthcare professionals, and why should this knowledge be applied in their work? In an academic context, it is common to seek explanations for the intrinsic benefits of performing good deeds, which may be related to notions of respect, empathy, and social and humane values. Such considerations can quickly become influential factors when contemplating acts of altruism. Thiscertainly might be an intrinsic motivation.

However, when interculturality and the need for a so-called cultural competence of medical personnel is introduced to the health sector,it often refers to the sheer acknowledgement that effective medical treatmentis impeded exemplary due to language barriers (Liet al. 2017). Effectiveness and successare frequently employed as overarching objectives of culturally sensitive healthcare. Furthermoreand not limited to language barriers, Alizadeh and Chavan (2020:233) would recall cultural awareness, the knowledge of it and respective skills as an "imperative when it comes to building proper communication with [.] clients, improving the quality of care for them and reducing medication errors". Culturallysensitive care therefore can lead to "improved treatment concordance" as well as "adherence" (Raffoul / Lin 2015:4). Like this, cultural competence became a key feature in establishinga standard for quality health care (Raffoul / Lin 2015). This is why, many attempts to link interculturality with the aim to improve health care on an interpersonal basis do call for more "intercultural competence" (Bein 2017), yet this is not often elaborated further other than "the ability to communicate and understand your own and other cultures' beliefs" (2017:283). There is always a comparison taking place as well as a distinction within the category *patient* as one counterpart in the questions of *inter*-culturality, whereas cultural competence usually is only expected from the side of physicians and other healthcare providers. The phenomenon that for instance, a "physician from Nigeria" (Driesch 2020:28) is afraid of not being perceived as competent by patients due to his external and physical otherness, is highly essential to discuss, yet not subject to training offers in this field.

Cultural competence as such becomes a soft skill that differentiates a good doctor or other healthcare workers from the contraryas patients then assumingly feel treated more appropriately to their own 'culturally influenced' needs (Flynn et al. 2020). Probably itcould be argued that interculturality can be sold as a product in this sense that is subject to an economic paradigm. This reckons with the notion that according to Kaihlanen et al. (2019:7) medical trainings of that sort should be "cost effective" ensuring as many healthcare workers as possible to make use of them. Sometimes this is even more vaguely framed for instance when "culturally sensitive health[care] for *ethnic minorities*", is said to "bring substantial benefits" (Eshiettand Parry 2003:229). That is probably the crux of the matter. Solely because what strikes here is the fact that repeatedly the proclaimed need for more cultural sensitive healthcare and the inherent call to train doctors and medical staff respectively is embedded in a broader conceptualisation of one specific goal: providing a solution for the growing "diversification of societies" and the challenges this imposes as the "the world is on the move, and the number of international migrants today is higher than ever before" (Handtke 2019:2, UN 2016). Consequently, the World Health

Organisation (WHO) jointly with the International Organisation of Migration (IOM) seems quite vague when it emphasises the importance of a healthcare system being capable of delivering healthcare from a patient-centred viewpoint for 'all kinds' of patients (IOM/WHO 2010). Correspondingly and in accordance with the diversification of societies, the said importance of patient-centred care from a practitioner's point of view, one of many aspects, is illustrated in the narrow realm of the so-called *Migrant Medicine*. This is further embedded in the narrated problem coming to terms that "doctors in multicultural societies are increasingly confronted with patients from various ethnic backgrounds" (Paternotte et al. 2017:170). This is not only the case for international organisations like the WHO, yet also finds its way into the justification of national guidelines. For instance, the preface of a recent intercultural communications guide and go-to handbook for physicians far away from any reflections states in its first sentence: "Germany is a country of immigration" (Gillessen et al. 2020:8). A few lines further on, it connects this statement by marking that apparently within medicine, intercultural communication therefore plays a fundamental role to the social integration of people with a said refugee and migration background. Hence, a good doctor is one that takes 'cultural' differences into account to not only ensure effective healthcare but also to fulfil a societal role.

When ethnicity is undifferentiated from a concept of cultureit is only logical to link this presumed fact to the viewpoint that it is precisely these ethnic differences between physicians and patients that are said to pose a challenge to effective communication and ultimately to the quality of health care in its entirety (Jacobi 2020, Paternotte et al. 2017). Practitioners therefore should merely know about cultural differences, be mindful about them in a second step and eventually "live diversity" by seeing itas an "enrichment of everyday practice" (Zaeri-Esfahaniand Biakowski 2020:20).

At the risk of sounding cynical it is as simple as that. On account ofhow intercultural counselling practices consequently look likein the clinical field this article asks more importantly, on what bases of cultural understandings are they constituted of? The following chapter is dedicated to these reflections.

2.2. What culture – what trainings?

If a linkage of intercultural counselling in the realm of medicine and health is theoretically introduced, it is worth looking into of how this field understands the definitory aspect of culture first and foremost. When going through certain literatures of existing health professional trainings or research that postulate the importance of intercultural competence, 'culture' often in a large sense is referred to as the

"integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups".
(Raffoul / Lin 2015:2)

While being essentialist this postulate is vaguely broad at the same time. In the context of client-centred work usually less broad understandings of culture such as solemn cultural differences or "different cultural dimensions" (Choi / Mckeever 2020:4036) are also observed that are often linked to national borders and geographical regions. For example, intercultural trainers in a broad term might explain that obesity in "parts of Western Africa" (Eshiett / Parry 2003: 230) is perceived as a sign of good health, while any health problems linked to it will be ascribed to forces beyond the obese person's control in 'those countries'. Other advocates of cultural sensitivity often underscore the importance of recognising the role of religion and spirituality, particularly due to the assertion that many people may experience an augmented spiritual need in times of illness (Bein 2017, Cook 2015). This is then used as a direct causality to show that religious beliefs apparently

strongly influence values and ultimately human behaviour. For instance, and in the example of intensive care medicine according to Bein (2017), many Muslims are to believe that they are not owners of their own body and therefore would not want to decide on whether to continue or withdraw intensive care treatment. On the other hand, he states that "most Western religions or cultures" (2017:230) would be more prone to that. This serves as one of many representative illustrations of the broader pattern observed across multiple training programs and their accompanying descriptions encountered in the course of this article.

Besides, in what way does this conceptualisation of culture and human beings influence how counselling practices in this field are described? For one, being culturally competent on the clinical level translates into being aware of these proclaimed differences, keeping an "open mind" while respecting and accepting other values as well as the "capability [...] to abstract from [...] own cultural, religious, and social values in the handling of *foreignness*" (Bein 2017:230). "Tolerance of ambiguity" (Gillessen et al. 2020:6) and "change of perspective" (Driesch 2020:27) are mentioned as useful attributes of a culturally competent doctor but are often not discussed further in detail and consequently left as inflated yet empty words. Furthermore, as mentioned before they are usually interpreted from the perspective of a national culture by means of either cultural cases or general descriptions as exemplified by (Golsabahi-Broclawski / Drekovic 2020). Others, like a recent study from Australia, might just simply fall back in time when culture is unquestioned misused for race. According to them, when interculturality is valued as a soft skill for doctors, trainings should subsequently provide "caregivers' [with] cultural knowledge and behavioural skills to bridge the distance in medical consultations in which doctors are of a different race from their patients" (Alizadeh, Chavan 2020:231). Auspiciously, not all surveys and trainings ground their work on such simplistic and scarce perceptions of culture which is welcoming. There are other understandings brought to the medical field that connote culture more in the sense of something that

"shapes the lens through which we each see and approach the world, and that we all belong to more than one culture (social, professional, or religious) that transcends simply our race, ethnicity, or country of origin" (Betancourt 2006:501).

The realisation that understandings of culture are constantly being questioned and therefore are a matter of complex, problematic, and frequently contested negotiations is mentioned and acknowledged in some publications (cf. Gregg / Saha 2006). However, this is often not applied further. Maybe that is not arbitrary as Betancourt (2006) logically concludes that

"this shouldn't preclude physicians [.] from striving to better prepare ourselves to understand and manage the multiple ways in which culture in the broadest sense manifests itself in the clinical encounter" (ibid, 502).

As follows, it is a broad sense for cultural understandings and hence differences that is seemingly looked for and is also considered sufficient to achieve the overarching goal of intercultural competence in a health setting (Paternotte et al. 2016).
Consequently, it comes as no surprise that this leads to trainings and respective knowledge transfer based on concepts that have been outdated for a while now, yet in medical settings appear as popular approaches. The cultural dimensions by Geert Hofstede or Edward T. Hall's high and low context cultures or monochronic and polychronic conceptualisation of time are still used repeatedly (cf. Choi / McKeever 2020, Kailahnen et al. 2019). Exemplarily, the above mentioned handbook for physicians in Germany on how to achieve intercultural competence, highlights the sheer knowledge of individualist and collectivist cultures, whereas they situate migrants with regards to the contrasted German society as collec-

tivistic (Zaeri-Esfahani / Biakowski 2020). Hence, many efforts have been made to teach medical staff about the values, attitudes and therefore predictable behavior of certain cultural groups by providing convenient "dos and don'ts" as guidelines that one simply needs to know about and consequently apply. Even though these approaches are highly as well as rightfully criticised for obvious reasons and not all training descriptions are based on providing checklists and culturally specific facts, they can still be found today. There are notions in medical educational texts that at least name attributes like curiosity, empathy, or respect (Betancourt 2006) and others that warn to use the term culture in health care inflationary or in any stereotype provoking manner (Gregg / Saha 2006). Efforts to "reflective practice" can also be found (Paternotte et al. 2016:1). Kaihlanen et al. (2019) for example tried to design trainings that take a more general approach in which awareness of different cultures is only possible "by scrutinizing one's own cultural features". Even though, the different cultural dimensions by Hofstede (1980) still served as a theoretical base, storytelling and constructivist learning theory was mentioned. This at least partially mitigates concerns raised by those who reject the use of checklists in favor of more context-specific approaches. However, none of these welcoming and more critical applications essentially moved away from the framework of immigration and ethnic minorities when being used for medical education. The analysis of medical counseling training programs described in the literature suggests that the prevailing understanding of culture in such practices may be outdated. Nevertheless, since the purpose of this article is to describe the current state of counseling in this field rather than propose a prescriptive alternative, the upcoming chapter aims to openly examine the phenomenon described thus far.

2.3. The medical lens on culture – the cultural lens on medicine?

On that account, even though there are notions of intercultural counseling practices in the doctor-patient relations that try to move beyond checklist thinking, the concepts of cultures used are almost exclusively those based on essentialist and positivist assumption building cultural blocks such as national identities, religion, and ethnicity. The perpetuation of specific concepts of culture and their application in the realm of healthcare, may mirror the obstacles encountered within education in intercultural communication itself. Namely, the continued utilisation and reproduction of concepts introduced by predominantly ‚western' scholars several decades ago. Such concepts continue to be employed, reproduced, and regarded as self-evident, highlighting the need for critical examination of their applicability in contemporary also in healthcare practice. As Dervin and Jacobsson (2022:25) state, this reproduction of old concepts stands "without being questioned, properly problematised, or more than marginally adjusted." Needless to say, such cultural perceptions pose a threat to truthful understanding of patients. That this can open the door for more problems than it intended to solve is undeniable. It will not only tempt physicians to make essentialist assumptions about an alleged culture and "oversimplify the fluidity of [.] and the diversity within cultures" (Betancourt 2006:499), but it can also foster and reproduce polarisation. Aside from this being a concern from an ethical or social justice point of view, it might not even be 'useful' for doctors as effective patient healthcare might still be impeded as soon as patients find themselves be put in boxes when being communicated with.

Therefore, the question derives: why do counseling practices in the individual clinical field still seem to be in their infancy? Might the reason for this lay in the nature of the discipline *Medicine* itself? Does the biomedical logic of disease –

at least in the western view of health – (Lokugamage / Ahillan / Pathberiya 2020) and like any natural or life science that works with clearly distinguishable categories, numbers, and scientific, evidence-based facts have anything to do with how social or cultural science knowledge is accepted and evaluated? Or do we portray a narrow-minded image of medicine with this that limits its far-reaching potentials of seeing beyond dichotomies? The concepts of culture and human behavior, such as those introduced by Hall and Hofstede, could be perceived as potentially useful by the field of medicine, meaning a sense of culture that

"people growing up in specific geographical and cultural contexts are categorised in relation to certain worldviews and are expected to behave accordingly, regardless of external conditions - people are what people are and, by knowing how they are, communication is facilitated".
(Dervin and Jacobsson 2022:27)

To work with clear, expectable outcomes might be appealing to medical personnel but this is of course open to brisk dispute. Other reasons why essentialist and positivist cultural blocks are still being portrayed in intercultural advocacy and training offers can be thought of. The problematic nature of linking the proclaimed need for intercultural competence to training offers only perceived useful within the broader societal phenomena of migration, is apparent. If cultural differences are only recognised alongside 'the migrant' or the 'obvious other' and not in everyday society, it comes as no surprise how the field of medicine and health thinks interculturality. Interculturality in medicine as such is still used to make sense of 'the Other'. Said underlying cultural understandings used in medical personnel trainings have the potential to only perpetuate this. When searching for training descriptions or publications in this field, most start with generic articulations such as: "Doctors in multicultural societies are increasingly confronted with patients from various ethnic backgrounds" (Paternotte et al. 2017) or: "The world is on the move, and the number of international migrants today is higher than ever before." (Handtke et al. 2019) With this, 'the Other' is always portrayed in form of non-western in comparison to 'us'.
As long as this practice is kept alive, re-thinking approaches are most likely not to be seen in the medical field very soon. To enrich this discussion, there is one other aspect worth mentioning to bring into this deliberation: the perceptions of physicians or other healthcare workers themselves and the question whether they deem interculturality counseling as useful and realistically successful. A recent study on mental healthcare in Germany published only in late 2022 by Schödwell et al. (2022:1309) describes how the "intercultural openness" of hospitals face certain difficulties when it comes to the actual application of it. One difficulty was described as the tendency of healthcare workers of falling into simplistic character deprecations, prejudices or even culturalisation of (migrant) patients in their everyday work. Culturalisation by the physicians was described as an exonerating attempt to cope with emotional stress in the face of lack of time and shortage of staff (ibid. 2022). Interestingly, inherent racism and culturalisation tendencies were thereby diverted from the individual physician's responsibility to a supposed consequence of the economisation of our health system in general and structural conditions of a hospital. It was argued that only after structural changes, an intercultural openness in forms of personnel trainings and would make sense. An interview with an employee illustrates this very well:

"On the whole, however, everyone tries to find a good solution. Under stress, the ‚good will' quickly tips back into prejudice. If there was more time, it would work. The problem is when it becomes too rigid [like]: 'But that's not how it's done here' [or] 'but we speak German here,' then conflicts often arise..." (Psychologist cited by Schödwell et al. 2022:1311).

The argument is made that even if practitioners were to have intercultural competence trainings, they would only come back to structures that do not support the intercultural openness institutionally in form of more funds for interpreters or staff for example. What does that tell us for the intercultural field and counseling work as such or rather does it tell us anything at all? While fully acknowledging this problem, does this just translate into an already suspected incommensurability of health, medicine, or care and interculturalism in general when being put off with said external justifications? Are limited time and resources valid reasons for not applying knowledge on implicit biases, inherent racist assumptions and stereotyping in health care? It may explain the usage of said concepts, yet how can this be soundly justified at all? Consequently, is interculturality only validated through a lens that follows a medical and more specifically healthcare logic with all its economic aspects? These deliberations remain open for discussion. The tenuous attempt to show how a linkage of intercultural counseling in the clinical field between a healthcare provider and a healthcare seeker can contemporarily be observable is by no means exhaustive. Health is more than the biophysical absence of infirmity or disease and goes beyond the question of blood levels and antibody counts. Where else can we think or re-think interculturality in the broad field of health? Moving from a tangible playground of health that takes interpersonal encounters in the medical field into consideration to a completely different scope and component of health: Global Health. The conception of health can transcend literal borders, in exemplary form of humanitarian aid or the endeavour of combating global diseases disregarding nation states such as the recent and ongoing COVID-19 pandemic. Consequently, in the next chapter I will focus on the notion of Global Health, as re-thinking approaches in using knowledge from postcolonial theories are potentially seen here and a current joint call to decolonise global health can be made evident.

3. Decolonising global health

When confronted with questions on how the role of postcolonial power imbalances in empirical research practice and the effects of othering and epistemic violence has been sensitised in the field of medicine and health in general everyone might inevitably stumble over the very recent and seemingly joint endeavour that calls for *decolonising global health*. If thoughts on 'colonialism' are merely sparked in a conversation connected to health, a discussion certainly ensues. Usually, almost exclusively you would find yourself in a justification debate, whilst taking a step back dealing with the often-posed question: why should medicine or global health be colonial in the first place? And eventually: why should the health field be in any way accused of being drenched in colonial continuities or neo-colonial structures? What might (and should) be clearly and undoubtedly self-evident to some, might result in skepticism to others. This is why the reader might understand the felt need to at least attempt some broader theoretical clarification first and particularly to shed light on what global health is and where it comes from to further understand where neo-colonialism comes into play, before any reasonable endeavour to decolonise this field would make sense. I fully recognise that the distinction between coloniser versus colonised or high-income country versus low-income country as well as Global North versus Global South are often scrupulously crude if not simplified dichotomies that not always portray the reality in its entirety clearly. Yet, for the sake of the analytical discussion, I still choose to make use of them as such in reflecting as well as in depicting what has been proclaimed so far.

3.1. From colonial to tropical medicine to global health

Koplan et al. (2009:1995) define global health as "an area for study, research, and practice that places a priority on improving health and achieving health equity for all people worldwide". With the hopelessly vague definition of health in general provided by the WHO, complexity only further entangles here with a sprinkle of equity on a global scale. Global health is a constant disputed area (Salm et al. 2021) and an "ongoing struggle" according to Abimbola (2018:63). Yet in brief, other than public health global health can be anything that focuses on emerging health challenges transcending national borders. These challenges often affect vulnerable populations that at least self-ascribed require global cooperation and a multidisciplinary approach to tackle (Elliott 2022, Chen et al. 2020). It is an academic field but also a practical one encompassing health interventions globally, medical trials and research, humanitarian or development aid in health and all actions related to that. Now importantly, the term 'global' health itself is misleading and hiding certain asymmetries. As Eichbaum et al. (2021:329) essentially state, global health is a "convenient but artificial construct" by high-income countries to describe health care that is practiced in low- and middle-income countries. The reason for that is, that global health as we know it today is by no means a new cosmopolitan endeavour aimed at combatting social injustice and health inequalities for all but actually finds its predecessors in Colonial and Missionary and later Tropical Medicine (Hirsch 2021, Abimbola / Pai 2020). To make a crucial and incisive history of devastating inhumanity and exploitation of others concise for this topic: Medicine and the work of physicians itself became a common and indispensable technique within the colonial apparatus. So called Colonial Medicine was essential as the success of the European colonisation project depended on the health of its agents (Neill 2012). The resulted postulated need to protect colonial nations' interests from "the threat of infectious diseases" (Kim 2021:2) consequently served as a powerful impetus to advance the field of modern medicine with "seminal discoveries" of up until today major infectious diseases and their treatment such as malaria or tuberculosis. The colonial exploitation was justified through discourses as well as structures that "advocated for the biological difference and ensuing political superiority of white Europeans" (Hirsch 2021:190). One could correspondingly contend that the concept of global health today is grounded in perceptions that have emerged from a "eurocentric imaginary of a world system" (Affun-Adegbulu / Adegbulu 2020:1) and a western concept of what it means to be human. Therefore, Tropical Medicine is strictly speaking not a medical specialisation based on medical facts but emerged during the late-nineteenth century and was "a direct result of [European] colonisation" (Castor / Borrell 2022:2) focusing on infectious diseases on the African continent and the southern hemisphere that were later framed the 'tropics'. The deeper the deconstruction of this notion unfolds, the more evident it becomes that "tropical medicine not only operated in the service of colonial exploitation, [but] was itself an exploitative practice" and was also "steeped in racist beliefs" stemming from physiological differences and the inherent notion of "different human races" (Fofana 2021:2). Faithful to the assumption that "different diseases attacked different races" (Neill 2012:66), some physicians believed that 'Africans' were particularly resistant against certain diseases and the environmental conditions while Europeans were not. Furthermore, this was entangled with the unquestioned belief that colonised people were to be deemed backwards, irrational and "in desperate need of the civilising and modern (also medical) influence of Europe" (Fofana 2021:2).

From a postcolonial lens, the idea of an evolution of mankind from a somewhat savage medicine to a civilised one as an universal and irreversible way to look at

the body, health and medicine as a whole needs to be clearly emphasised here. To speak with Holliday and Amadasi (2020:20) the "western gaze" becomes undoubtedly evident in this understanding. 'Modern' medicine itself can consequently be seen as one representation of modern western culture among many. Furthermore, if someone were to venture to explain the persistent colonial legacy of the modern Global Health system, it would be prudent to draw upon Kim's (2021:2) discussion of the „explicit" and „implicit functions" of the system. The *explicit* function can be understood as the knowledge that was generated during the era of Tropical Medicine and that then contributed to the improvement of health of affected populations. Simultaneously however, that knowledge had an *implicit* function that protected the interests of the colonisers and thereby legitimised the unjust power dynamics between them and the colonised. Health as such can be seen as Pierre Bourdieu would call it "the left hand of the state" (Horton 2018:2484). One could even use Michel Focault's (2008:140) coined notion of *biopolitics* or *biopower*, when applying this to actions in the name of Global Health that aim to achieve "the subjugations of bodies and the control of populations". Be that as it may, health in an institutional manner and in the dichotomy of the *Global North* and *Global South* is never free of power dynamics.

Now, the accusation of coloniality of global health therefore stems from the fact that in the name of "health and well-being for all" (Elliott 2022:176) this once historic described asymmetry between the 'developed' and 'underdeveloped' humans is still uphold today. When it comes to decolonising global health institutions, there is typically a "dismissal of how the institution's racialised origin diminishes agency for non-white people" (Koum Besson 2021:2328). Nevertheless, the global health system still legitimises inequalities, social injustice, and discrimination often so subtle on the basis of a supposedly higher ethos. This "saviourism mindset" (Fofana 2021:3) is rooted in the ideal that any health or disease-control intervention is better than none and forms part of the narrative of the benevolent (western) person that we see in contemporary humanitarian aid work as well. For example, portraying Africa as "the disease-ridden rural continent" (Affun-Adegbulu / Adegbulu 2020,:2) unable to help itself in crisis is relentlessly portrayed in aid campaigns and media coverages as only one of many neo-colonial reproduction of the sector we can observe today (Martens / Oomen 2020). The global rhetoric and portraying of disease during the Ebola outbreak in West Africa are a testimony of this "dehumanisation of black and brown peoples" (Affun-Adegbulu / Adegbulu 2020:1, Hasian 2019). On that score, global health today still echoes a "colonial grand narrative" (Holliday and Amadasi 2020:17) often without seeming to accept or fully realising it. Stemming from its colonial legacy the global health concept is under heavy accusation of still perpetuating a system of inequalities, hierarchisation of people and knowledges and therefore inevitably producing and re-producing processes of 'othering'. Furthermore, despite the legal formal abolishment of colonies, the system is under accusation of still creating dependencies of the Global South, fostering "epistemic injustice" (Koch 2021:18) and of upholding a narrative of superiority (Eichbaum et al. 2021). The list of global health practices that are colonial legacies is long. It includes anything that preserves the „inferior status" of those on the „receiving ends of the global health services" (Kwete et al. 2022:3). Importantly, systems that perpetuate power imbalances in global health are not confined by geographical boundaries. They are found in organisations based in low- and middle-income countries as well (Khan et al. 2021).

To link coloniality with the understanding that it is not a relic from the past but continues to find its way into the present, becomes more tangible when we look at the Covid-19 pandemic. Not only did inherent racist attitudes rise to

the surface whilst labelling the pathogen as the 'Wuhan' or the 'Chinese Virus', resulting in Asian populations worldwide "being scapegoated and facing discrimination" (Büyüm et al. 2020:2). Moreover, the pandemic in its peak also offered a "timely lens" making continuous influences of colonialism and coloniality in the field of global health visible (Fofana 2021:1). Numerous metaphors have been used to illustrate this intensification of the problem all of which came to similar if not the same conclusion. Hence, Covid-19 could be understood as a "mirror" as well as "magnifying glass" like Byatnal (2020:1) among others would frame it or the pandemic functioned as a "spotlight" on existing inequalities and on processes of coloniality affecting everything like Abimbola et al. (2021:2) states it. Practicing a "vaccine apartheid" (Bajaj / Maki / Stanford 2022:1452) means that the Global South was and is dependent on the "generosity" and "benevolence" of other nations to donate unused inoculants (Chaudhuri et al. 2021:2). The disproportionate allocation of vaccines by the Global North, resulting in an abundance of vaccine doses for their own population, while many other countries have not received any doses is a "stark indication of power asymmetry in global health" (Abimbola et al. 2021:2). Judith Butler (2022:62) strikingly captures this in her latest work illustrating how the pandemic intensified a racial and hence "radical inequality" in a political power play of whose life matters and whose death is preventable. An alternative thought for this disparity during the Covid-19 pandemic, and the power imbalances that the Global North perpetuates, can be found in Achille Mbembe's concept of „necropolitics" (2019). This notion highlights how the Global North reinforces the division of the world by exploiting the basic and universal concept of life and death. Instead of working towards the self-proclaimed solidarity and equality as a global health system, national borders where strengthened and security measures were put into place (Butler 2022).

In sum, here are many ways in which learnings from interculturality and postcolonial thought could be taken into account to potentially untangle this web of the global health field. Hence, it will be interesting to grasp what has been on the agenda of this endeavour so far. What does it mean to de-colonise global health? The following chapter focuses on the diverse attempts to gift that question with an answer.

3.2. What now? – peace to the (colonised) huts, war on the Master's house?

Even though the call to decolonise systems like global health is not an innovative nor new one, the endeavour gained more attention and prominence in the last two years. This intensified after the police murder of George Floyd and the followed "contextualisation of the Black Lives Matter movement" (Koum Besson 2021:2328) in the United States. Furthermore, growing calls to decolonise global health were not only sparked within protests or student groups but are also reflected in the "rapid growth of academic literature" surrounding this prominent issue (Hellowell / Schwerdtle 2022:1). As a reaction and according to Hirsch (2021:189) schools of global health have made positioning statements and have "avowed to address racism, increase staff and student diversity, and to train their staff in the art of decolonisation". Summer schools, working groups, international symposia series and many other platforms have taken up on this topic ever since. Nonetheless, it is worth mentioning that these movements have emerged predominantly within universities in the Global North (Lawrence / Hirsch 2020). In fact, many institutions recited a call to equity and highlighted the importance of decolonisation within their own narratives but "did not self-acknowledge or describe plans to address these within their institution" (Castor / Borrell 2022:2). The observation made by Mogaka, Stewart and Bukusi (2021:1) that decolonisation efforts are both „welcome but also worrisome" is grounded in

the critical realisation, evident in various literatures and readings that suggestions for decolonisation vary greatly. With that, and despite a shared understanding to shift power in all its forms, there is a lack of „clear plans on how to make this suggestion a reality“ (ibid. 2021:2). Put differently, there seems to be a consensus, yet it remains “somewhat elusive” (Rivera-Segarra et al. 2022:2) on how to step away from pure rhetoric to actual action.

To provide some analytical guidance: there are two main ways being proclaimed a decolonisation of the global health field can focus on. One is a more tangible and measurable approach ranging from changing financing structures of the system to moving institutions' headquarters to the Global South or abolishing international tuition fees for respective people. Kwete et al. (2022:6) even claim that the “end goal” of decolonisation should be an “equitable economic ownership of the global wealth”. The other approach is situated on a more narrative and epistemic basis. “Decolonise our minds” (Abimbola et al. 2021:3) as a humble ambitious endeavour so to say as Thiong'o (1986) has already framed it decades ago. Eurocentric und universalistic mindsets should be dispelled and the “European lie” in its civilising mission should be “de-mythologized” (Rutazibwa 2018:163). Of course, both foci are not to be separated from each other in application and they are obviously connected. However, the latter is probably the more crucial approach when looking at the question on how interculturality can interplay in this field. How decolonising our minds is understood can vary greatly. In a satirical manner Jumbam (2020, 1) provides some guidelines on how not to behave as a global health researcher if health equity actually stands inherently at the center of your work. “You are primarily a global health practitioner and not a historian or anthropologist” and that entails you to “not spend too much time studying the historical, cultural, anthropological, political and sociological contexts” and most certainly: “don't bother with trying to understand the complex intricacies and relationships between these and health”.

Additionally, many researchers are calling for global health research to be led by local leaders in low- and middle-income countries and demand that indigenous voices should be heard (Oti / Ncayiyana 2021). Some argue that this does not go far enough and call for a radical transformation as the only reasonable response in combating a system based on ‘white supremacy’ (Hirsch 2021). The question hereby is whether any substantial change will be achieved by decolonial framed practices and reforms whilst remaining within the same structures one is trying to change. Correspondingly Ferri (2022:6) strikingly summed up the fundamental proposition in Audre Lorde's (2003) vital essay: *The master's tools will never dismantle the master's house*. In that she illustrates the dilemma that “the other [colonised] can only acquire a voice when using those tools that have been forged by th[e] universalised self [coloniser]”. Following this argument, this means that any decolonial endeavour that does not dismantle the system or at least its current structures as a whole can intrinsically not sustain. All changes then would be merely cosmetic.

Applied to the health sector this can be exemplified by a recent promotion video *Doctors without borders* or *Médecins Sans Frontières* (MSF) have published only in December of this year after heavy criticism from the global decolonisation movement of bearing institutionalised racism and working in white supremist structures (Marjumdar 2020). The video shows a diverse MSF local team, recalls its colonial past, and eventually tries to break with dichotomies of *us* and *them* or *heroes* and *victims* (MSF 2022). What content wise seems legit at first glance, remains however pure rhetoric. It is not taken into account, that interculturality here just as Ferri (2022:2) would state in the context of academic institutions has become an instrument of policy initiatives that advertise themselves “as diverse and internationalised”, while at the same

time within these same institutions issues of representation and privilege remain "unproblematised and unquestioned" (ibid. 2022:3). The fact that MSF hires alleged local staff for their missions that are educated in the Global North fully assimilated and conditioned to the status quo of the 'West' does not make it truly diverse. Lioba Hirsch (2021:190) would name this a "tokenistic hiring" practice in an attempt to give an answer to colonialist and racial accusations while keeping the structures intact. And in alignment with Audre Lorde: one cannot decolonise a system while still keeping its epistemic, political and financial power – by keeping the "*Master's house*" intact.

Assimilation and conditioning are not decolonial practices. It is not just now that Frantz Fanon (1967) reminds us in *Black skin, White masks* about the unbearable necessity to wear a 'white' mask to survive in a 'white' world. The ideal would be a decolonised and decentralised global health, one that "moves beyond tokenistic box ticking about diversity and inclusion into developing new structures and processes that can address power asymmetries" (Abimbola et al. 2021:9). However, how such structures and processes should look like remains vague and unanswered in the field of global health. Now, what can be made of this unclear and somewhat elusive project of connecting post- and decolonial thought into the field of health on a global scale? The proposition that the global healthcare community and practitioners have appropriated the call for decolonisation, initially spurred by the COVID-19 pandemic and the global BLM movement, as a mere „buzzword" (T. Khan 2021), is a matter of significant concern. The accusation that decolonisation can be dismissed as merely a buzzword and a movement that brings no real consequence must be taken seriously. In fact, not everyone agrees with the basic logic of global health's seamless connection to historical colonialism. Hellowell and Nayna Schwerdtle (2022:3) claim that even though global health institutions were established during times of the European colonial project, it nonetheless "does not follow that pervasive remnants of supremacy must persist". They state that the development from Colonial Medicine to Global Health can also be perceived as progress – a progress that is now endangered and disregarded with a said decolonising call. Current inaction and denial of effective change might also be explained with this. How this could solemnly functions as a counter narrative that plays with the former explicit functions of global health while hiding implicit ones is subject to discussion and cannot be answered here.

On a different note, according to Hirsch (2021:190) there is a risk that this crucial effort and the true postcolonial work is pushed away "by flashy consultants and everyone's scramble to prove their decolonial credentials". To prove own decolonial credentials without offering a clear plan on how to make that ideal a reality can stand as proof of a prioritisation of self-interest over 'good intentions' and the question still remains: Can the intercultural field offer consultation work that is the opposite of 'flashy'? If furthermore, decolonising can also mean to recognise that some people in the global health community especially in the Global South have tried to change the system from within for a long time without recognition and to not treat it like a new critique emerging just now, what can we draw from this? Is has not changed anything so far since Fanon's revolutionary call to radical decolonisation in 1961 with his seminal book the *Wretched of this Earth* or Spivak's *Can the subaltern speak?*. That the pandemic has shown. Will cultural theory, paradigm shifts, and postcolonial thinking therefore ever be successfully applied in this field? Or will it remain an academic sideshow solemnly capable of offering a mirror to inequalities, hierachisations of people and unhealthy power dynamics? The final lines of this article are consequently dedicated to discussing this phenomenon.

3.3. Discussion: Uncomfortable perspectives

Why, if the necessary knowledge and critical theoretical reflection is 'there' does a field like medicine and global health still not apply these pragmatically? To paraphrase it with Koum Besson (2021:2328):

"Despite public statements to the contrary, the reluctance of some academic institutions to mandate anti-racist education and appropriately fund efforts to decolonise teaching and research practices in public and global health is disheartening. Arguably, such statements mainly served to mitigate reputational risks and publicly assuage white guilt after centuries of inaction." (ibid. 2021)

The answer to why only cosmetic changes are at the forefront that sustain disguised supremacy probably might be that the questions of decoloniality are highly uncomfortable to those accused. For those operating within the humanitarian aid sector, where the prevailing „narrative of charity" (Kim 2021:3) emphasises the virtue of ‚doing good', such a proposition may present a challenge to comprehend. Not to sound excusive yet "the cognitive dissonance on this topic is striking" (Koum Besson 2021:2328). Making use of Han's (2021:1) perception of our society that according to him is characterised by algophobia – the fear of pain: "we live in a society of positivity that tries to extinguish any form of negativity". This means all pains are avoided and whenever a conversation threatens to be uncomfortable we tend to avoid it. Avoiding topics that are uncomfortable can result in a dissonance that even further perpetuates inequity across global health organisations. This can impede decolonisation according to Caster and Borrell (2021:1) "by and in the institutions that promote global health, and undermines the achievement of current goals across the global health system." What we can make of the field of health is that notions as decoloniality are rising as a "challenge to the average biomedical view of [...] health" (Lokugamage et al. 2020:5). Actually tolerating the ambiguity that the somewhat triumph of western medicine is a contingent perception of health then becomes an almost idealised task. This epistemic enlargement of the field to other voices in this discourse, other concepts of health and understandings of healing and disease would certainly enrich the joint global task of health to all. The spectrum of such topics, ranging from traditional healing practices to cultural beliefs about disease, is broad and multifaceted. However, it is important to note that delving into each of these areas would go beyond the intended scope of this article.

Despite that, recognising and understanding one's own eurocentric biases as being part of a colonial grand narrative can be very uncomfortable. Accepting own unconscious perpetuations and reproduction of inequalities even more so. Thereby: Questioning health and (western) medicine intrinsically through the means of postcolonial thought does not mean siding with the 'evil', the 'irrational' or coming to terms with the fact that evidence-based science in health is somewhat delusional. Of course, true decolonisation would probably mean in the end to dismantle the system entirely, figuratively speaking taking out the symbolic sledgehammer and tear its structures to the ground. However, practically speaking that is highly unlikely nor do we not have the moral right to simply withdraw from any global health action currently in place. Even if the system is characterised by dependencies and unhealthy power dynamics, these dependencies are real and have consequences. Humans being treated or cared for still rely on them. Simply leaving that in the name of decolonialisation would only be further diminishing the cracked sense of solidarity this 'western' world employs. Decolonial endeavours on a narrative basis however are long overdue. Decolonial thought in health should be an offer to move beyond "white guilt" (Koum Besson 2021:2) and a way out of the "cognitive dissonance" (Castor / Borrell 2022:3) in the end. This can also be applied to

the perception of disease in general and how a doctor treats patients that do not 'believe' in the same biomedical hegemony. The interplays of interculturality in the medical field are so multifaceted and interconnected, it is almost impossible to keep them analytical apart. The reason why many intercultural trainings for medical staff are currently still holding on to outdated concepts of culture that enable continuous 'othering' of people might be embedded in that same unquestioned state of superiority and privilege.

4. Conclusion

This article sought to show that despite initial re-thinking approaches there is still a huge discrepancy between research knowledge in interculturality and application of it in the field of medicine and health. While counseling practices that highlight the importance of cultural competence in healthcare settings can be made evident, many still appear to be limited to outdated essentialist and positivist cultural concepts. To gain insight into how a field such as medicine conceptualises notions of culture, this study intentionally adopted the understanding of competence, whether cultural or intercultural, as used synonymously within the clinical field. This approach was preferred rather than using academic and abstract definitions of the terms as it allowed for a clearer and more profound exploration of how the medical profession treats cultural concepts. Nonetheless, what calls for greater intercultural competence in clinical encounters have in common is their contextualisation and rationale in migrant and multi-ethnic societies. The sole comparison of proclaimed differences in cultural essentialist blocks stemming from this logic might impede true interculturality and not even help the medical field in its goal to effective healthcare at all. The article discussed potential reasons and implications for this phenomenon ranging from the hypothetical underlying medical lens of culture itself to imminent practices of 'othering'. Hence, within topics such as the so-called migrant medicine and culture sensitive patient care, the question whether the health sector in its work ethos will move beyond knowledge and assumption building on essentialist and positivist understandings of culture remains debatable.

Moving to a different scope and conception of health, in terms of global health the article presented an initial approach to the emerging decolonisation endeavour in global health that was fueled by the pandemic and sparked by the Black Lives Matter movement. It shed light on the implicit colonial embeddedness characterised by epistemic injustice and power imbalances in the global health system. Yet, this sensitization to interculturality and postcolonial thought in the field of global health remains vague and unclear in terms of practical application so far. Despite the paradigm shifts in cultural theory, they have not translated into a radical transformation of the global health system. The article also discussed cognitive dissonance and the uncomfortable task of exposing eurocentrism as potential reasons for inaction, as well as the alleged accusations of superficial changes as pure self-interest induced decolonial positioning of the privileged. These sections highlight the current challenges interculturality and its knowledge transfer face in a practical and distinct field of health. This article provides a contemporary snapshot and a stimulus for further intercultural work and discussion. The overarching question remains whether re-thinking or even thinking about intercultural communication consultancy in the complex field of health will move beyond an academic sideshow that can only offer critical reflections on the current status quo.

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