Cuadernos Interculturales
ISSN: 0718-0586
cuadernos.interculturales@yahoo.es
Universidad de Playa Ancha
Chile

Santos, Saul; Verdín Amaro, Karina
Intercultural communication issues during medical consultation: the case of Huichol people in Mexico
Cuadernos Interculturales, vol. 9, núm. 17, 2011, pp. 257-271
Universidad de Playa Ancha
Viña del Mar, Chile

Available in: http://www.redalyc.org/articulo.oa?id=55222591016

How to cite
Complete issue
More information about this article
Journal's homepage in redalyc.org

Scientific Information System
Network of Scientific Journals from Latin America, the Caribbean, Spain and Portugal
Non-profit academic project, developed under the open access initiative

Intercultural communication issues during medical consultation: the case of Huichol people in Mexico *

Comunicación intercultural durante la consulta médica: el caso de los huicholes en México

Saul Santos **
Karina Verdín Amaro ***

Abstract

The Mexican Ministry of Health, as a response to the State's official acknowledgement of the cultural diversity in the country, has promoted a program that incorporates a socio-cultural dimension in medical attention. This program encourages healthcare providers to seek information about the characteristics of indigenous ethnic population regarding cultural aspects, including language. In this paper we show that although understanding cultural aspects of indigenous groups is crucial in the development of a culturally-sensitive view of health care service provision, it is also of paramount importance to observe aspects concerning intercultural communication issues, such as differences in expectations regarding medical consultation between an indigenous patient and a non-indigenous physician. These differences may lead to bias in health service provision which may ultimately affect patient satisfaction, adherence to treatment and subsequently, health outcomes.

Key words: Health provision disparities, intercultural communication, Huichol patients, medical consultation

---

* Recibido: junio 2011. Aceptado: octubre 2011.

Este artículo forma parte del proyecto SIP11-005 "Estudio sobre la comunicación intercultural entre pacientes indígenas de la región del Gran Nayar y profesionales de la salud mestizos", registrado en la Universidad Autónoma de Nayarit con vigencia a diciembre 2013.

** Universidad Autónoma de Nayarit, México. Correo electrónico: saulsantos@hotmail.com

*** Universidad Autónoma de Nayarit, México. Correo electrónico: karinaivett@hotmail.com

Resumen

La Secretaría de Salud de México, como respuesta al reconocimiento oficial de la diversidad cultural en el país, ha promovido un programa que incorpora la dimensión sociocultural en la atención médica. Este programa recomienda a los prestadores de servicio que busquen información acerca de las características de los grupos étnicos con respecto a aspectos culturales, incluyendo el idioma. En este artículo mostramos que si bien entender aspectos culturales de los pueblos indígenas es crucial en el desarrollo de un programa culturalmente sensible, es de suma importancia, asimismo, también tomar en cuenta aspectos relacionados con la comunicación intercultural, como es el caso de las diferencias en las expectativas de lo que es la consulta médica entre un paciente indígena y un profesional de la salud mestizo. Estas diferencias pueden sesgar la prestación de servicios, lo cual, en última instancia, puede afectar la satisfacción del paciente, la adherencia al tratamiento y subsecuentemente su salud.

Palabras clave: Comunicación intercultural, consulta médica, huichol, disparidades en el servicio médico

1) Introduction

Mexico is a country of richness in many senses, one of them being its cultural and linguistic diversity: there are 67 officially recognised indigenous ethnic groups and the number of spoken languages far exceeds that figure. This large variety of languages represents a great challenge for the State in terms of healthcare service provision. Evidence of this is a high incidence of health-related problems among indigenous ethnic groups that are otherwise prevented and have a low impact in non-indigenous rural communities. The Mexican Ministry of Health has officially acknowledged these disparities and that they are due to the fact that the model of health service provision is hegemonic in that it officialises and imposes a specific vision of health, disease, life, death, the human body, and so forth; in other words, it has institutionalised a so-called 'western' vision of health.

In order to improve the quality of health service provision for indigenous ethnic groups, the Ministry of Health has developed a program that incorporates a socio-cultural dimension in medical attention, referred to as *An intercultural approach in health service provision*, which encourages healthcare providers to seek information about the characteristics of the target population regarding cultural aspects, including language.

Looking inside an indigenous society or any cultural group should, undeniably, prepare the ground towards an intercultural communication, because this culturally-sensitive approach should help interlocutors to raise awareness on the actions people take during interaction in which differences produce sources of conflict in power and

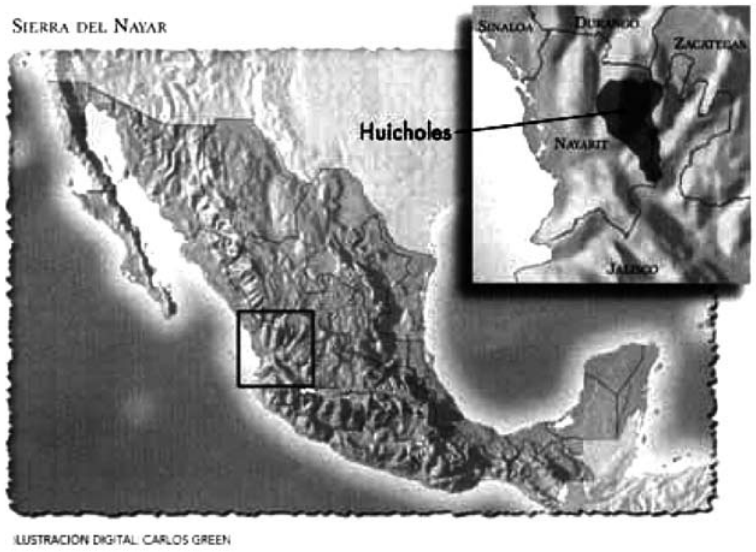
in understanding. However, these actions are based on tacit norms; and in order for the healthcare provider to become aware of them, they must be made explicit.

In other words, training in intercultural competence for health care providers should promote not only an understanding of the social and cultural influences on patients' beliefs about health and disease, but also, and above all, aspects concerning intercultural communication issues, because differences in intercultural communication may alter the way health service are provided, ultimately affecting health outcomes.

2) Huichol people and healthcare provision

Huichol people dwell in the *Sierra Madre Occidental* range, in the Midwest region of Mexico (See Map 1). Their language, *Wixárika*, belongs to the Uto-Aztecan language family. According to the 2005 census report, there are 35 724 speakers of *Wixárika*, which represents the 0.59% of the indigenous population in Mexico. Fewer and fewer communities are exclusively monolingual *Wixárika* speakers. In fact, only 11.4 % (4 070 speakers) of the Huichol population is *Wixárika* monolingual, although the level of bilingualism varies, with a strong tendency for younger people to be more fluent speakers of Spanish, even at the expense of *Wixárika*.

Map 1: Location of huichol territory



Most indigenous communities in Mexico have a functional specialization of the indigenous language and Spanish. Spanish is used in the so-called higher functions such as 'national' government issues, 'national' healthcare system, the media and education. Interestingly, the use of *Wixárika* in Huichol communities is not only confined to the home and other personal domains of interaction between community members; it is also used in higher functions such as 'traditional' government issues, the performance of rituals including those related to health service provision via traditional healers or *mara'akate* (plural of *mara'akame*, Huichol shaman).

By law, when an indigenous patient uses the 'national' healthcare system, an interpreter should be provided. Very often, however, interpreters are not available for a number of reasons. State hospitals, like in many countries, work on limited budgets. This forces them to prioritize their needs. In the region where Huichol people live also other three indigenous ethnic groups live and they often share the same hospitals. Each group respectively speaks a different language: *Wixárika, Nayeri, O'dham* and *Nahuatl*. In cases like this, only interpreters of the indigenous languages spoken by the majority are provided, hence the available interpreter does not speak the same indigenous language as the patient. Also, the service of interpreters is provided at specific times of the day or specific days of the week. For instance, in the hospital where part of this research was carried out, in the mornings from Monday to Friday the interpreter is a Huichol speaker, there is no interpreters in the afternoons; on Saturdays the interpreter is a speaker of *Nayeri* and on Sunday the interpreter is a speaker of *Nahuatl*.

If an interpreter is not available, patients are required to bring a bilingual relative to serve as an interpreter, and this may include children. One fundamental problem here is that these improvised interpreters are not trained either as interpreters or in healthcare issues. An interpreter works as a bridge between the healthcare provider and the patient and as such, he or she must have, on the one hand, linguistic and experiential knowledge of the so-called western medicine and, on the other, the ability to explain and express the patient's symptoms which may be expressed by the patient in accordance to his or her understanding of illness (Hanssen & Alpers, 2010). This is especially important if one accepts that communication during consultation should also help build trust and understanding (Nailon, 2006).

When the Huichol patient is bilingual, Spanish is used. Healthcare providers are not trained to deal with communication aspects of intercultural encounters even when the program *An intercultural approach in health service provision* is in operation. The program emphasises the idea of different people having different representations and beliefs regarding health and disease, that each people has a different way of taking pain and even the death of the human body, and that those beliefs lead the way they prevent disease, relieve pain, recover health and prolong life. Whereas in general terms the program sets the conditions for health care providers to better understand and help the patient as a whole person, and promotes an intensive covera-

ge of certain tests, procedures, medicines and treatments among indigenous patients, it does not consider an aspect of paramount importance if one is to bring down health service provision disparities: differences of interpersonal aspects of healthcare.

3) Differences of interpersonal aspects in medical consultation: does ethnicity matter?

Communication during consultation should have the ultimate intention of building trust on the side of the patient. This trust may, in turn, help the patient to understand the process of his or her disease and to accept a diagnosis and a consequent adherence to treatment. Lack of training of the healthcare provider in issues of intercultural communication may lead to misunderstanding between healthcare professionals and patients during medical consultation. Even when interpreter services are offered, especially in the conditions they are provided for Huichol patients, communication may fail if interpreters are not specially trained.

An important number of studies, mainly carried out in the United States, reveal that, among other traits, ethnicity has been found to play a prominent role in bias during medical healthcare provision (see e.g. Schulman et al., 1999; Weisse et al., 2001). Indigenous ethnic groups in Mexico, like many black and Hispanic people in the United States, are an often segregated minority: they are socioeconomically disadvantaged, have low levels of education, and live in areas where there are great environmental hazards. All these traits have been identified as sources of bias in healthcare provision.

Despite the fact that both diagnosis and treatment of disease are based on research protocols, discourse used during consultation in the context of public consultation in Mexico often remains at the level of the plausible or probable: in other words, research on actual interaction in medical consultation is urgent. The following analysis attempts to open the floor for research-based discussions on this respect.

How is this ultimate intention described above achieved? According to Adam (1986) and Bateson (1966) discourse studied as an instance of communication with natural intentions maintains an *argumentative function* which intends to "get the interlocutor to believe" or "get the interlocutor to do" something. How is the patient persuaded or convinced? Do physicians use similar strategies with patients who are indigenous and those who are not, even if the former speaks Spanish as a second language? Translation does not guarantee effective communication among people who belong to cultures with different languages, or even if they share a common language. Different cultures have different ways of approaching life. In the domain of health, for example, it has been confirmed that different cultures have different ways of explaining life,

wellness, illness, or death, and those beliefs may affect the way they communicate illness (Barzini, 1965; Zolla, 2005).

Huichol people have a totally different way of performing rituals concerning healthcare. Santos & Verdín Amaro (2011) explored issues regarding how communication is been established between the healthcare provider (a *mara'akame* or shaman in their case) and the patient. They found that although in appearance the structure of the basic healer-patient interaction during a '*limpia*' or cleansing is similar to what happens in a consultation between a non-indigenous physician and patient, they are fundamentally different in aspects regarding verbal dominance, content of interaction and non-linguistic elements of the exchange, specifically the use of silence.

In principle, interactions in the context of medical consultation are asymmetrical in that the patient is subordinate to the healer (Tannen, 1992). In the context of the *limpia* process, although there is still a level of asymmetry imposed by the power and authority of the healer in the community, there seems to be a certain level of solidarity. This can be explained in terms of socio-cultural aspects surrounding the *limpia* process.

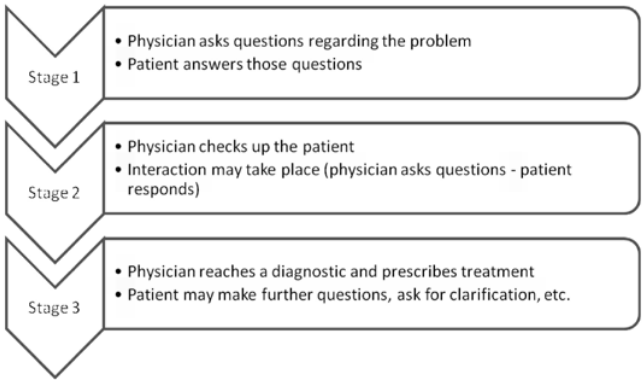
Recovery of balance (healing) of a Huichol patient often depends on the entire family or even on the involvement of all members of the community. During the process of *limpia*, members of the family of the patient are present. It is assumed that from the moment the patient comes into the room where the *limpia* is to take place, the healer 'knows' what the problem is about, but in certain instances, the patient has to add information. Interestingly, any interaction at this point does not have to do with the patient's symptoms, but rather with actions the patient or a family member did or neglected to do, places they visited, people they talked to, objects that were touched, and so forth. Generally the patient knows about what he or she has to talk. The decisions of what to say in relation to what needs to be known in order to arrive at a diagnostic is permeated by our understanding of issues such as what causes a disease or a state of imbalance, and how it is corrected or alleviated. A Huichol perspective assumes that both parties in the interaction (patient and *mara'akame*) share this kind of knowledge, hence the patient is in a position to decide what might be relevant; this shared knowledge may allow some solidarity. In addition, towards the end of the *limpia*, the *mara'akame* offers explanations that are in full agreement with the systems of beliefs of the Huichol patient about health and disease, life and death, balance and imbalance, and gives precise instructions about what needs to be done. It is during this stage that the *mara'akame* explains to the patient and his or her family the nature of the problem, and the patient knows that healing depends on obeying instructions.

It should be pointed out that it is not assumed that a *limpia* is an equivalent of the medical consultation. For the Huichol people, it does not make much sense to talk about health and disease (in the western sense), rather one can talk about a *state of balance or wellbeing*. The state of balance is sustained as people have a harmonic relationship with their ancestors and their environment; failing to do this will disrupt this state of balance. The state of wellbe-

ing is called *'aix+a nepereu 'erie*. The opposite is *nepereu kuye* (imbalance). Although the concept behind *'aix+a nepereu 'erie* is similar to the western concept of health, the concept of *nepereu kuye* differs from the western concept of sickness, since *the state of imbalance* affects not only the individual but somehow the whole family or community. Rather than being a threat to the body or a part of it, *nepereu kuye* is a threat for the spirit and the stability of the culture itself. This imbalance is made manifest in a 'magical' way through the introduction of foreign entities to the human body (Vazquez Castellanos, 1992).

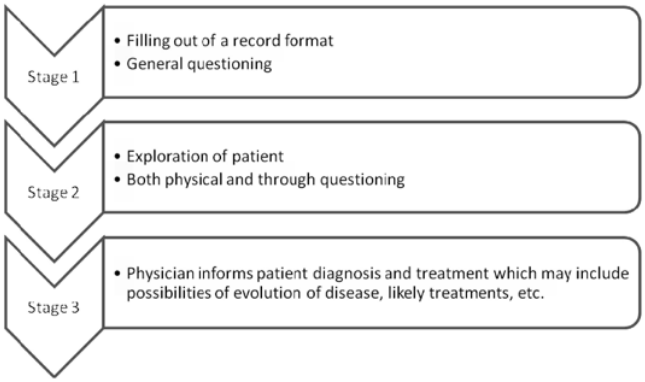
The reason the *limpia* is mentioned here is because it is believed that for Huichol patients it is an important reference point for the medical consultation as a communicative act, and expectations of what should happen at the doctor's office in terms of who speaks, when and about what might be permeated by what happens during a *limpia*, shaping the way Huichol patients approach medical consultation in a Spanish speaking context. Santos & Verdín Amaro (2011) describe medical consultation between a non-indigenous physician and a Huichol patient as taking the following structure (Chart 1):

Chart 1: Structure of a consultation between a non-indigenous physician and a Huichol patient



Is interaction different when consultation takes place in a context where both the patient and the physician are non-indigenous? Interestingly, Carbajal (2010), who analysed 30 medical consultations between non-indigenous patient and physicians in an urban public hospital in Mexico, found that medical consultation takes in average 15 minutes per patient distributed as shown in chart 2 below:

Chart 2: Structure of a consultation between a non-indigenous physician and patient



At first sight, interactions in both contexts are similar. In the analysis that follows we will try to show that they are indeed fundamentally different.

The medical consultations with non-indigenous patients analyzed show that physicians tend to help patients build trust. One strategy employed by the physician is to socialize with the patient, as shown in the following segments, where the physician is checking up a patient and they engage in a conversation about the patient's daughter:

(A1) Physician: 'Does it hurt here?'
(A2) Patient: 'Yes, it's been bothering for a couple of days now'
(A3) Physician: 'I see... What does your daughter do?" (This question is askedwhile the physician is checking up the patient)
(A4) Patient: 'She's a veterinarian'
(A5) Physician: "Is she doing fine?"
(A6)Patient: 'Yes, she's been there for four years'
(A7) Physician: 'God bless her... I hope everything goes on like this. Well then...'

(Physician keeps asking questions about the pain...)

As can be seen, in (A1) and (A2) the doctor is talking about the problem; however, when the physician starts checking up the patient, it seems he feels the need of filling silent spaces. In western cultures, silence is regarded as meaningless and not contributive in conversation (Jaworski, 1992). This space could be filled with questions related to the patient's problem, but very often, physicians decide, as in (A3), to fill it with social talk. We believe that this small conversation is employed not only for the purpose of filling silent periods, but as a strategy to establish rapport, which may, in turn, help build trust.

Interaction can become more personal, as shown in the following segment of interaction. We believe that conversations of this tenure are possible only because both physician and patient share cultural values:

(B1) Physician: 'I see you are a bit sad. How are things? Do you believe inGod?'
(B2) Patient: 'If I told you... I don't believe in Him or anyone else'
(B3) Physician: 'Nit in Him or anyone else?'
(B4) Patient: 'It is because of all these things that have happened to me lately'
(B5) Physician: mmh
(B6) Patient: 'I say "How can this be possible?"'
(B7) Physician: 'That God allows all this?'
(B8) Patient: 'That God send all those things to me and not to him (her husband)...'
(B9) Physician: 'Right'

In medical consultations with indigenous patients physicians show some attempts to help the patient to understand the process of his or her disease, but they do not seem concerned with trying to build trust.

In the context of the United States, black and Hispanic patients have been found to receive less information, less supportive talk, and less proficient clinical performance, shorter, more physician verbally dominated and less patient-centered visits than white, middle class patients (Johnson et al., 2004; Frank, 2010). Observations carried out by Author of interactions between non-indigenous physicians and Huichol patients confirm this. In the following segment the patient is received by a nurse, who is a native speaker of *Wixárika*. The nurse confirms some personal information and the reason for the visit. This encounter takes place in *Wixárika*. The patient is subsequently sent to the doctor's office, who is a native speaker of Spanish. The nurse summarizes the physician the conversation with the patient. Almost invariably, the physician starts the interaction asking about symptoms, with no warm-up, as shown in the following segment of conversation:

(C1) Physician: 'What color is mucus?'
(C2) Patient: 'White'
(C3) Physician: 'Transparent or white? Like water?'
(C4) Patient: (nods)
(C5) Physician: 'Have you had temperature?'
(C6) Patient: 'Yes'
(C7) Physician: 'Are you allergic to any medication? That gives you rash or spots?'
(C8) Patient: 'No'

(Physician silently examines the patient and prescribes treatment)

Apart from the absence of this small conversation in interactions with indigenous patients, the segments in (A) and (B) reveal a combination of monosyllabic and longer chunks of utterances on the side of the patient, whereas in segment (C), the consultation with an indigenous patient, the interaction is verbally dominated by the physician, with a prevalence of yes/no questions uttered slowly and loudly and monosyllabic responses of the patient. It is clear that no effort on the side of the physician is made to establish rapport with the patient.

Another factor that may impede the establishment of trust between physicians and indigenous patients is misunderstanding caused by differences in expectations regarding verbal participation and pauses during interaction. From a western perspective, speaking or speaking out signals power, liberation, culture or civilization itself whereas silence signals nothingness (Steiner, 1998), but this is not universal.

Expectations regarding length of pauses (*silence)* plays an important role in the attitude both the physician and the patient toward each other. Huichol patients are described as using long pauses during communication compared to the '*norm*' between non-indigenous physicians and patients. When the expectation the physician has regarding the shape interaction should take in a consultation (e.g. regarding turn-taking and the use of silence), he or she may make assumptions about the patient (e.g. that he is uncooperative or that he does not understand Spanish) and in consequence may change his or her approach to the interaction (e.g. by speaking slowly and louder, or by restricting himself or herself to making questions or giving a prescription, without further involvement). The following account given by a physician during an interview conducted by the researchers illustrates this. The interview was carried out in *Ocota de la Sierra*, an indigenous community in the State of Jalisco, México.

> "Interviewer: Do you have communication problems with your patients?
> Physician: Yes, all the time. The other day, for example, a young woman came to the hospital with a baby in her arms. She sat there and stayed still, without saying a word. So I asked her what seemed to be the matter. She did not respond. I asked her if the problem was with her baby. She remained silent, with her body like this (shrank forward and her face looking down). Then I asked her the age of her baby. Again, no response. When the baby was born, no answer. Then I got upset and told her that I was not a magician and that I was not able to guess what the problem was with the baby. Still no answer. Out of impatience, I started asking specific questions: Does your baby have a runny nose? The woman just nodded with her head. I made some more questions associated with the flu and she nodded after each question. I am sure that if I had asked about a hearth stroke she would have nodded… I wanted to kill her because she didn't speak."

Scollon (1985) found that perceived differences in timing during turn-taking have an impact on interpersonal judgments in both interlocutors (i.e. they may develop a negative attitude towards each other).

At first sight it seems that the patient is being uncooperative. However, after having worked in Huichol communities for a number of years, we know that it is not the case. Silence and long pauses between turns in interactions are commonplace on everyday conversations. Long pauses and silence signal much more than uncooperativeness (c.fr. attributable silence). Jaworski (1992), for example, asserts that attributable silence can carry five types of functions: judgmental, affective, linkage, revelatory and activating. None of these seems to explain the patient's behavior described in the interview above. Santos & Verdín Amaro (2011) noticed that silence among Huichols is rather a sign of respect and that they are thoroughly thinking about what they are going to say (see also Becker, 1992). A swift response may be taken as if the person is not giving importance to the matter. Further, long pauses or silence are more marked when the speaker is not acquainted with the interlocutor. As can be seen from this interview, the possibility of establishing rapport was lost due to the fact that the physician was not able to understand cultural differences regarding silence.

Another difference in the two context analysed here is that with non-indigenous patients, the physician often tries to help the patient to understand the process of his or her disease. In the following segment, the physician prescribes some medicine and explains the patient why she should follow the treatment and the consequences of not doing it:

(D1) Physician: 'You are going to take *omeprazol* so your tummy is fine'
(D2) Patient: 'Yes'
(D3) Physician: 'Yes? Omeprazol... Let's see, Omeprazol... we are going to take a little pill in the morning and one at night, but only for fifteen days , no more...'
(D4) Patient: 'Yes'
(D5) Physician: '... remember, acid plays a fundamental role in the process of absorption of food nutrients...'
(D6) Patient: Yes
(D7) Physician: 'If you take *omeprazol* all the time there isn't acid in your stomach, and your stomach is not going to absorb vitamin B1, vitamin B6, bitamin B12...'
(D8) Patient: 'mmh'
(D9) Physician: 'Then next time I see you, you are going to have a severe case of anemia...'
(D10) Patient: 'Ok, so I have to take it only for two weeks...'

This kind of additional information is scarce in interactions with Huichol patients, as illustrated in the following example:

(E1) Physician: "You are going to take these medicines. You are going to take this three times a day and this other five times a day. The first will help you with the cough and the second with the headache and temperature. Take care and do not go out of your house at night because it's windy."

Although the physician explains what each medicine is for, she is not clear about when exactly the patient should take the medicine and for how long. A more subtle detail in this interaction has to do with the warning the physician gives the patient. For a non indigenous patient it makes sense to hear that one should not go out of the house if one does not want to get exposed to the cold wind; however, Huichol houses are cold and windy because of the way they are constructed, and the patio is part of the house. Very often, if they are cold inside a room, they go out to the patio to get warm around a bonfire. Clearly, although the physician was well intended, intercultural differences may affect the impact of the warning. We see, then, that on the one hand the physician is more laconic in his or her interaction with the indigenous patient, perhaps due to the fact that he or she devaluates minority group patients and their needs, he or she work in the conviction, perhaps justified, that the patient understands little or nothing regarding the process of the disease (see e.g. Cooper & Roter, 2003) and on the other hand, when the physician attempts to give advice, intercultural issues may interfere.

The analysis also showed differences regarding patient involvement regarding diagnosis and treatment. Carbajal's database (2010) shows evidence of requests of clarifications on the side of the patient, as shown in the following segment. In the first example, the physician prescribed a new medication:

(F1) Patient: '*Diclophenaco*? How will that help me?'
(F2) Physician: '*Diclofenaco* is like a big *mejoral*. Do you know *mejorals*?'
(F3) Patient: 'Yes, I have plenty of them at home, but they don't help me'
(F4) Physician: 'They don't help you... well then, have you taken another analgesic?'

In this second example, the physician prescribed the patient several medications:

(G1) Patient: 'Can I take them at the same time?'
(G2) Physician: 'Sure, no problem'

Finally, in this example the patient discusses alternatives of treatment:

(H1) Physician: 'I'm giving you this medication to stop your throwing up'
(H2) Patient: 'Can I have that as an injection?'

Even when at this limited level, non indigenous patients ask for clarification and negotiate treatment or medication. Huichol patients seem to have a

more submissive attitude, as shown in segment (C), and in the analysis presented in Santos & Verdín Amaro (2011). They tend to accept the treatment with no overt questioning, although this does not necessarily guaranty adherence to treatment. Elsewhere, it has been found out that ethnic minority patients tend to have a limited involvement in medical decisions (Cooper et al., 1999; Saha et al. 1999). Research shows that often, patients belonging to ethnic minorities in the United States are indeed less prompt to demand or even request first class attention. This may be perceived by healthcare providers as a negative or uncooperative attitude on the side of the patient, reinforcing a stereotype that these patients have low expectations, limited capacities or not clear desires.

This limited involvement may also be attributed to preconceived stereotypes that healthcare providers have about certain ethnic groups (Cooper & Roter, 2003). These stereotypes may influence healthcare providers' beliefs about, expectations of, and attitudes against patients (van Ryn & Burke, 2000). In other words, the attitudes or assumptions healthcare providers make about their patients have implications for the care they give.

4) Whose role is it to improve medical communication in intercultural settings?

In Mexico by law, and in general by society, healthcare providers are expected to offer all patients, regardless particular socioeconomic, educational, and racial traits, equal attention. Although patient-healthcare provider communication research in Mexico is scarce we believe that held stereotypes regarding indigenous patients have resulted for many years in disparities in the provision of healthcare services.

Earlier in this report we mentioned that the Health ministry in Mexico, as a response to the State acknowledgement that the country is culturally diverse, has promoted an intercultural health program for indigenous minorities. We have explained that this program, although well-intended, is limited in that even when it takes into consideration the social, historical, cultural and religious context within which it occurs, it does not deal with issues regarding intercultural communication. Intercultural differences in communication, as it has been evident, affect the interpretation of the meaning of anything that is conveyed (Bradby, 2001; Lewis, 2000).

In this article we have tried to show that even when at a surface level medical consultation with an indigenous patient is the same as when the patient is not indigenous, a closer look reveals that there are fundamental differences and these differences may result in an unequal access to medical services. Specifically we have tried to make the point that when expectations of one or the other (physician / patient) may be different this results in changes of attitude towards each other.

In other words, in order to understand healthcare disparities it is necessary to explore issues related to patient-healthcare provider communication. It should be noted, however, that the rules that govern communicative acts such as medical consultation are not always overtly known by the speakers, hence differences are not readily identified or even expected (people are now generally aware of these rules and/or that others' behaviors may be governed by different rules).

Training for health care providers should include specific training in intercultural competence. This intercultural competence implies not only an understanding of the social and cultural influences on patients' beliefs about health and disease, but also, and above all, aspects concerning intercultural differences in expectations on both sides of the different communicative acts surrounding health care provision. Research on the specific context of patient-physician intercultural interaction in the Mexican context is scarce. This report shows on the one hand, the methodological possibilities of observations in issues regarding intercultural communication and, on the other, demonstrates how well-meant political strategies can result in asymmetric service provision if not based on research within the target population and if they are not mediated with deep reflection from their perspective. We hope this report elicits further discussion.

5) References

Barzini, Luigi (1965): *The Italians*. New York: Bantam Press.

Becker, A. L. (1992): "Silence across language: an essay". In: Claire Kramsch & Sally McConnell-Ginet. *Text and Context.Cross-disciplinary perspectives on language study*, pp.135-147. Lexington: Heath and Company.

Bradby, Hannah (2001): "Communication, interpretation and translation". In: Lorraine Cully & Simon Dyson (eds.), *Ethnicity and Nursing Practice*. New York: Palgrave.

Carbajal, Aldo (2010): "Análisis del discurso médico: la argumentación en la consulta púbica". Unpublished MA Dissertation (Applied Linguistics). Guadalajara-Mexico: University of Guadalajara.

Cooper, Lisa & Debra Roter (2003): "Patient-Provider Communication: The Effect of Race and Ethnicity on Process and Outcomes of Healthcare". In: Brian D. Smedley, Adrienne Y. Stith, & Alan R. Nelson (ed.), *Unequal treatment: confronting racial and ethnic disparities in health care*. USA: National Academies Press.

Cooper, Lisa, et.al. (1999): "Race, gender, and partnership in the patient-physician relationship". *Journal of the American Medical Association*, Vol. 282, Nº6, pp.583-589. Chicago: American Medical Association.

Frank, Danielle, et.al. (2000): "Primary care physicians' attitudes regarding race-based therapies". *Journal of General Internal Medicine*, vol.25, Nº5, pp. 384 – 389. Indiana: Springer.

Hanssen, Ingrid & Lise-Merete Alpers (2010): "Interpreters in Intercultural Health Care Settings: Health professionals' and professional interpreters' cultural knowledge, and their reciprocal perception and collaboration". *Journal of intercultural communication*, vol.23. Consulta mayo 31 de 2011: http://www.immi.se/intercultural/

Jaworski, Adam (1992): *The power of silence: social and pragmatic perspectives*. California: Sage Publications.

Lewis, Richard (2000): *When Cultures Collide. Managing Successfully Across Cultures*. London: Nicholas Breley Publishing.

Nailon, Regina (2006): "Nurses' concerns and practices with using interpreters in the care of Latino patients in the Emergency Department". *Journal of Transcultural Nursing*, vol.17, Nº2, pp.119-128. Livonia, MI: Transcultural Nursing Society.

Saha, Somnath et.al. (1999): "Patient-physian racial concordance and the perceived quality and use of healt care". *Archives of Internal Medicine*, Vol. 158, Nº9, pp.997-1004. Chicago: American Medical Association.

Santos, Saul & Karina Ivett Verdín Amaro (2011): "Health care provision in a huichol community in Mexico: an issue of intercultural communication". *Journal of Intercultural Communication*, vol.26. : http://www.immi.se/intercultural/

Schulman, Kevin et.al. (1999): "The effect of race and sex on physicians' recommendations for cardiac catherization". *New England Journal of Medicine*, Vol. 340, Nº8, pp.618-626. Waltham, MA: Massachusetts Medical Society.

Scollon, Ron (1985): "The machine stops". In: D. Tannen, & M. Saville-Troike (eds.), *Perspectives on silence*. Norwood, NJ: Ablex.

Steiner, George (1998): *Language and silence: essays on language, literature and the inhuman*. New Heaven-USA: Yale University Press.

Tannen, D. (1992). Rethinking power and solidarity in gender and dominance. In C. Kramsch & S. McConnell-Ginet.*Text and Context.Cross-disciplinary perspectives on language study*. Lexington: Heath and Company, pp 135 – 147.

Van Ryn, Michelle & Jane Burke (2000): "The effect of patient race and socioeconomic status on physicians' perceptions of patients". *Social Science Medicine*, Vol. 50, Nº6, pp.813-828. Amsterdam: ELSEVIER.

Vázquez Castellanos, José Luis (1992): "Práctica médica tradicional entre indígenas de la sierra madre occidental: los huicholes". In: E. Menéndez y J. García de Alba (compiladores) *Prácticas populares, ideología médica y participación social, aportes sobre antropología médica en México*. Guadalajara: Universidad de Guadalajara / CIESAS

Weisse, Carol, et al. (2001): "Do gender and race affect decisions about pain management?" *Journal of General Internal Medicine*, Vol. 16, Nº4, pp.211-217. Indiana: Springer.

Zolla, Carlos, et al. (1994): "*La medicina tradicional de los pueblos indígenas de México*" (3 vols.). México: INI