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Cultural Competence and the Role of the Patient's Mother Tongue: An Exploratory Study of Health Professionals' Perceptions

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Abstract: The role of the patient's mother tongue in clinical communication is of vital importance and yet it is not always dealt with adequately by healthcare professionals and healthcare systems. Cultural competence should deal with and redress asymmetries in doctor–patient communication, including those having an impact on the patient's mother tongue. The aim of this study was to answer a research question: what are the health professionals' perceptions of the importance and role of the patients' mother tongue in diglossic situations? To answer our research question, we carried out two focus groups, one with doctors and another with nurses working in public hospitals in the Valencian Community (Spain) where two languages share officiality, Catalan and Spanish. Yet, Catalan is a right and Spanish a duty. The results showed that perceptions of professionals in relation to the importance of the patient's mother tongue in situations in which two official languages coexist in an asymmetric relationship vary a great deal and seem to form a continuum of positive and negative judgements. Different values were represented in the participants' perceptions, ranging from respect for and full alignment with the patient's perspective to negative perceptions. More qualitative and quantitative research on health professionals' attitudes and values is needed to understand the role of the patient's mother tongue in clinical communication. Educational and institutional efforts are also needed to redress the linguistic and cultural asymmetries that have a negative impact on patients in terms of inequality, inefficiency, and even exclusion.

Keywords: cultural competence; cultural asymmetries; patient's mother tongue; health professionals' perceptions; dominant language; minoritized

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1. Introduction

In this study, we focused on language needs, and more specifically, on those arising from the use of patients' mother tongues in contexts in which two official languages coexist in an asymmetric relationship. The aim of our research was to answer a research question that we consider to be relevant to better understanding the cultural competence of health professionals: what are the health professionals' perceptions of the importance and role of the patient's mother tongue in such contexts. In this paper, we will first review the concepts of culture and cultural competence from the perspective of healthcare systems, medical professionals, and translation professionals. We will also consider some asymmetries in doctor–patient communication. We will then present and discuss the results of an exploratory empirical study carried out by the Gentt research group on Informed Consent and its use in clinical settings, focusing specifically on the problem of the use of the patient's mother tongue. In the last section of Final Remarks and Conclusions, we will point out some recommendations to improve public health policies and the training of future health professionals.

Culture is indeed a complex concept and definitions of culture vary widely, but most understand it as a socially acquired value system that serves as a frame of reference for

individuals. For example, for Spencer-Oatey [1] (p. 3), "Culture is a fuzzy set of basic assumptions and values, orientations to life, beliefs, policies, procedures and behavioural conventions that are shared by a group of people, and that influence (but do not determine) each member's behaviour and his/her interpretations of the 'meaning' of other people's behavior." Olalla [2] (p. 137) argues that "culture is made up of a group of individuals, regardless of how many there are. The key is not the number, but the fact that the individuals share a core system. (...) the inhabitants of a region or a country can be a culture. Culture provides the group of individuals with a common framework for perceiving, modifying and interpreting the world." In Hofstede's view [3] (p. 10), we can establish different levels of manifestation of culture: "a regional and/or ethnic and/or religious and/or linguistic affiliation, as most nations are composed of culturally different regions and/or ethnic and/or religious and/or language groups." Schmid [4] (p. 48) underlines the fact that we can find "smaller cultures within a language community that conceptualize aspects of the world differently and thus have to resort to processes of translation in order to guarantee successful communication among each other." In this paper, we will focus on two notions of culture of special relevance to our research: (a) culture in national/ethnic/linguistic terms, and (b) culture in socio-professional terms [5]. Asymmetries in doctor–patient communication can arise from both. In this paper, we will call them interlingual and intralingual asymmetries, respectively.

If we take culture in ethnic/national/linguistic terms, it constitutes a fundamental notion for the study of interlingual asymmetries concerning multilingual contexts. As pointed out by Montalt [6], in health contexts, multilingualism in societies is relevant on at least four levels. First, it exists globally in international communication in the provision of public health information: for example, international health organizations, such as the World Health Organization, circulate pandemic data and warnings in several major languages; scientific information originally published in English in international research journals is then translated and recontextualized in multiple languages and countries. Secondly, multilingualism is present in well-established local or national communities, where two or more languages are used by many (or all) of their members in their health systems. Thirdly, globalization and the mobility of the population have increased multilingualism and the need to cater for it in healthcare. In today's multi-ethnic and multilingual societies, intercultural and interlingual communication is proving to be essential. Finally, multilingualism also results from displacement caused by disasters of all sorts, such as climate crises, wars, or poverty [6]. Interlingual translation used to overcome language barriers and exclusion is a key issue in this first type of asymmetry.

Regarding intralingual asymmetries, communication between experts and non-experts can be described as the relation between different discourse communities [7] with distinct socioprofessional cultures within the same national/ethnic/linguistic culture. We can talk, for example, of the culture of patients suffering a given disease or the culture of cardiologists. From this socio-professional cultural perspective, it can be argued that Spanish, Italian, and British cardiologists share more in common in terms of discourse (not national language) and knowledge regarding their discipline and profession than, say, British cardiologists and neurologists [8] (p. 106). Of particular interest for doctor–patient communication are the asymmetries regarding register; that is, intralingual asymmetries. Intralingual translation—i.e., adapting, simplifying, or making content explicit to adapt communication to a non-expert audience such as patients—is of particular interest to overcome register barriers and the risk of exclusion of patients that they pose.

In this section, we explore these two kinds of asymmetries from the perspective of cultural competence. Doctor–patient communication in clinical settings typically involves intralingual or register of asymmetries and, in multilingual contexts, it also often involves interlingual asymmetries. In the next section, we will focus on one aspect of the first kind of asymmetry, in particular, the mother tongue of the patient in diglossic societies. Considering these two types of asymmetries, it is relevant to define the concept of cultural competence in relation to both health systems and healthcare and translation professionals.

Following Betancourt et al. [9], The McCourt School of Public Policy, of the Health Policy Institute of Georgetown University [10], defines cultural competence as the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients. A culturally competent health care system can help improve health outcomes and quality of care and can contribute to the elimination of racial and ethnic health disparities. Examples of strategies to move the health care system towards these goals include providing relevant training on cultural competence and cross-cultural issues to health professionals and creating policies that reduce administrative and linguistic barriers to patient care. Among the factors considered by the Health Policy Institute to cause disparities are race and ethnicity, language and communication barriers, or low literacy.

If the professionals, organizations, and systems are not working together to provide culturally competent care, patients are at higher risk of having negative health consequences, receiving poor quality care, or being dissatisfied with their care. According to the Health Policy Institute, the goal of culturally competent health care services is to provide the highest quality of care to every patient, regardless of race, ethnicity, or cultural background. Among the most relevant strategies for improving the patient–provider interaction and institutionalizing changes in the health care system are: providing interpreter services; recruiting and retaining minority staff; providing training to increase cultural awareness, knowledge, and skills; incorporating culture-specific attitudes and values into health promotion tools; including family and community members in health care decision making; or providing linguistic competency that extends beyond the clinical encounter to the appointment desk, and other written materials [11].

To achieve culturally competent systems and professionals, there is a need for healthcare education, which can be defined as the education that should be provided to health professionals, patients, and their relatives to help them live, both individually and socially, healthier lives by improving their physical, mental, emotional, and social health. Increasing their knowledge about health, influencing their attitudes about caring for their well-being, and ensuring that communication is carried out considering the cultural context in which healthcare education takes place are crucial aspects. In multilingual contexts, translators and interpreters can play a vital role as mediators in intercultural communication. In fact, Nisbeth and Zethsen [12] (p. 96) argue that:

> This means that healthcare professionals and authorities need to tailor their communication to laypeople, and also that medical knowledge and texts must be translated intralingually within the same national language, from expert language to plain language. Many of these medical texts are translated interlingually as well (...) and often, a combination of inter- and intralingual translation takes place, putting additional demands on the time and effort of the translators.

Organizations such as the Society of Teachers of Family Medicine [13] have developed guidelines for curriculum material to teach cultural sensitivity and competence to family medicine residents and other health professionals. These guidelines focus on enhancing attitudes in the following areas: awareness of the influences that sociocultural factors have on patients, clinicians, and the clinical relationship; acceptance of the physician's responsibility to understand the cultural aspects of health and illness; willingness to make clinical settings more accessible to patients; recognition of personal biases against people of different cultures; respect and tolerance for cultural differences; or acceptance of the responsibility to combat racism, classism, ageism, sexism, homophobia, and other kinds of biases and discrimination that occur in health care settings.

Among the different structural models developed to teach these skills, the one proposed by Kurtz and Silverman stands out [14]—that is, The Calgary-Cambridge Guide—is of special interest. Its aim is to define the curriculum and organize the teaching in communication training programs. It is a general, all-encompassing conceptual framework within which to organize the numerous skills that are discovered gradually as the communication curriculum unfolds. As highlighted in Montalt and García-Izquierdo [8] (110 ff), the guide

is structured in six sections: initiating the session, gathering information, structuring, building the relationship, explaining, and planning and closing the session, which are developed in specific tasks, skills, and stages. While it can be argued that the cultural issue is present in most sections directly or indirectly, it is particularly significant in the section "Building the relationship" (points 23–32), which focuses mainly on listening to the patient as an individual and using empathic communication. However, the mother tongue of the patient is not addressed as such, and this is precisely the focus of our paper. As seen above, some of the fundamental strategies to achieve a culturally competent health system are to provide interpreter services and linguistic competency to professionals, which is especially relevant in health care in multilingual, bilingual/diglossic contexts because language and communication barriers can affect the amount and quality of health care received. Therefore, the role of translators, interpreters, and mediators in relation to cultural competence is essential.

In linguistics and translation studies, culture plays an important role. In particular, it is a central concept in functionalist theories of translation, since every communicative action takes place in a given situational context and the text is always the result of a cultural action and interpretation. The function of a text is always culturally determined [15,16] and, consequently, communication has a relativistic character, since it depends on the interpretation of the receiver. That is why every mediation professional has to have a solid cultural competence.

According to Witte [17], cultural competence is acquired through socialization. The translator has an expert responsibility as an intercultural and interlinguistic mediator in the resolution of possible asymmetries. She states that the translator must have the ability to become critically aware of what one 'knows' unconsciously and to 'learn' consciously what one does not 'know' about one's own and other culture(s), as well as the ability to relate and contrast these cultures in order to be able to receive and produce behavior in accordance with the communication goal and oriented to the communicative situation, with respect to the communicative needs of at least two actors from two different cultures, in order to make communication between these actors possible.

As mentioned above, among the four possible scenarios, in our empirical study, we focused only on the second one, which in our case, is characterized by a social and cultural asymmetry between languages because one of them is dominant and the other is minoritized: "In multilingual societies, not all languages enjoy the same status and prestige, and often one of them is dominant. This means that it is often used as a common language of preference in public information and communication processes." [6].

In the context of our study, the relationship between dominant (Spanish) and minoritized (Catalan) languages can be seen as a social bilingualism and reflects a specialization of function similar to what can be found in diglossic contexts, where there is linguistic division of labor distributed between H (high) and L (low) varieties or languages. H is normally—although not exclusively—used for formal functions in more public situations, such as education, administration, healthcare, or religion, whereas L is normally—although not exclusively—used in informal or colloquial communicative situations, such as in the family or among friends. However, diglossia is a controversial concept [18] and we will not use it in an operative way. The above-mentioned division of labor is not and cannot be understood as a mere structural feature of a bilingual community. The fact is that the division of labor between Catalan and Spanish in the Valencian Community reflects minoritized situation of the latter and the dominant role of the former. By default, Catalan is not normally used as H. Spanish is H in the healthcare system for different reasons.

The relationship between health professional and patient is always, as we will see, asymmetrical in socioprofessional and epistemic terms. First, the doctor/nurse is in a position of power that is institutionally sanctioned. The patient is always in a vulnerable position. Second, the patient is more capable of expressing her experience of illness in her mother tongue than in a language—the dominant language—in which she is not necessarily fluent. Third, the patient is more capable of understanding the doctor/nurse in her mother tongue. In addition to understanding the meaning of the messages, empathy also plays an

important role in the interaction. Empathy can be enhanced through closeness, identity, etc. Fourth, Spanish is the dominant language in which health professionals have been educated and trained as such. It is the anonymous (following Woolard's terminology [19]), detached language of science, medicine, and health—in other words, of expertise—where the referential function is dominant. Catalan is the language of authenticity and identity, where the "indexal function" is dominant [19].

A relevant body of literature shows that the lack of a shared language between patient and doctor is a major cause of health disparities in healthcare [20–23]. Language barriers can be a major obstacle to history taking [24], and more so in complex, uncertain clinical contexts such as the emergency department. The socio-professional asymmetry inherent between doctor and patient is increased when the patient does not speak the institutional language; that is, the language that is used by medical staff [20]. In their study, they argue that one of the reasons clinicians do not invoke professional interpreters is that it is very cumbersome to effectively assess the patient's language skills. Zun et al. [25] found that both patients and clinicians often overestimate the patient's skills in the institutional language, something the call "false fluency" of the patient.

Hemberg and Sved [26] studied a different dimension of the asymmetries between patients and doctors as far as the patient's mother tongue is concerned. They analyzed the perceptions of a group of Swedish-speaking Finns whose mother tongue was Swedish (also an official language in Finland, where Finish functions as H and Swedish as L) and who had experience of hospital stays in southern Finland. The main theme was "Quality of care may be enhanced through care in one's mother tongue". The researchers showed that not being understood and not understanding can be considered suffering related to care particularly in cases in which patients may feel unsafe, sad, ashamed, or alone. These researchers showed that language touches on a significant emotional dimension and helps preserve personal and linguistic identity. Their study also revealed that patients felt vulnerable and that their confidentiality had been breached and their autonomy compromised when their next of kin acted as language brokers.

In the following sections, we will present the results of one recent empirical study carried out by the Gentt group to find out the perceptions of healthcare professionals on the role of the patient's mother tongue in the case of IC. The results of our study can be used to complement and contrast those from the studies we have just reviewed, which are focused on the patients' point of view.

2. Materials and Methods

With the aim of improving communication between specialists and patients, in recent years, the GENTT group has carried out research in clinical contexts involving groups of interest such as patients, nurses, and doctors. In these contexts, the existence of asymmetries that hinder communication between patients and health professionals has been shown. The data we used in this exploratory study on the role of the patient's mother tongue came from a bigger qualitative and quantitative research project about informed consent (IC). In it, there were questions regarding language issues and the existence or lack of translation and interpreting services. To answer our research question, we used part of the results of two focus groups, one with doctors and another with nurses. In October 2020, in the context of the HIPOCRATES research project, we conducted two focus groups with 7 doctors and 7 nurses.

The focus group is a qualitative method that allows opinions of the participants to emerge in a spontaneous way, together with those of other people with similar experiences who can enrich or contrast their perceptions. A focus group is a useful qualitative methodological tool when it comes to achieving the reproduction of social and professional habits and perceptions with respect to other agents. The decision of dividing the health professionals into two groups (doctors and nurses) derived from the need to check whether the attitude of both groups of professionals in relation to the issues addressed was similar and whether or not it could be considered that there was a different discursive (sub)community

behavior: nursing professionals vs. medical professionals. The division enabled us to analyze and interpret differentially the relevant aspects regarding their expectations, experiences, and orientations. The processing of the data was anonymous, and the identity of the participants was protected using an alphanumeric key (D1, D2, etc., and N1, N2, etc.). The semi-structured interviews were performed protecting the privacy of the data, and under no circumstances was personal data such as name, surname(s), NIF, NIE, passport, or census address be collected. The data collected will be treated in the strictest confidence. The data will not be processed individually, which will make it impossible to identify the persons involved.

The variables considered for the selection of the practitioners participating in the research were: (1) they had to be doctors and nurses, (2) with more than three years of experience (more than 3 years practicing medicine), and (3) who worked in the national health service in the Valencian Community.

The professionals were recruited using a blind recruitment method. The snowball sampling technique was used, based on the initial proposals of two doctors and two nurses. They were paid for their participation.

Once the participants had been recruited, these were the resulting characteristics of the population under study:

- Age. The age range for doctors was between 28 and 61, and between 27 and 51 for nurses;
- Specialty. Doctors: 1 bone, 1 oncology, 1 eye, 2 radiooncology, 1 kidney, 1 internal medicine. Nurses: 1 midwife, 1 obstetrician, 1 lung, 2 oncology, 1 primary care, 1 neurology. Geographical origin—doctors: 5 from the Valencian Community, 1 from the Basque Country, and 1 from another Spanish autonomous region; nurses: the Valencian Community;
- Mother tongue. Doctors: 4 bilinguals (Catalan and Spanish), of which 2 do not normally speak Catalan, and 3 Spanish speakers, of which one comes from the Valencian Community. Nurses: 5 bilinguals (Catalan and Spanish) and 2 monolinguals in Spanish;
- Gender distribution between male and female participants: three men and four women for doctors, and seven women for nurses (nursing is still a highly feminized profession in Spain and no male nurses engaged in our study).

The participants of the study had all been selected from the national health service in the Valencian Community: Vinaròs, Provincial, General, La Plana, Ribera, Sagunt, where, as mentioned above, both Catalan and Spanish are co-official languages, and yet Catalan is a right and Spanish is a duty and there is no administrative requirement to make sure that all healthcare professionals are competent in both languages. As a consequence, not all health professionals were necessarily competent in both languages.

In order to preserve the anonymity of the participants, the coding used in the Results section was based on 4 parameters:

- Type of professional (doctor, D, or nurse, N), numbered from 1 to 7 in each case;
- Gender (male, M, or female, F);
- Origin (Valencian Community, CV, or Not Valencian Community, NCV);
- Bilingual or not bilingual (B, NB).

Data were processed through the transcription of the focus groups and grouping of the information around the thematic areas, including language issues, textual comprehension, shared decision making, or relevance of communication in the medical act of IC in clinical practice. Regarding the language issue, which was our main focus in this study, special emphasis was placed on the use of the patient's mother tongue.

3. Results

In the two focus groups, both doctors and nurses recognized that:

- The main value of using Catalan is to bring proximity to the conversation with the patient. The idea that the best way to communicate with the patients is through their language is shared by all.

- Elderly patients from inland, underpopulated rural areas have difficulties in expressing themselves in Spanish and they feel more comfortable and communicate better when faced with a health professional who is fluent in Catalan.
- It is important for each patient to speak in their own language, as this is the most sincere and comfortable way of expressing their personal experiences.
- Taken together, the two focus groups expressed a major theme of interest: attitude and behavior in the interaction with patients. Code switching appeared to be one of the main issues in this theme. We found different scenarios, which can be summarized as follows:

a. The health professional's mother tongue is Spanish and, although they do not know Catalan, they are willing to establish a bilingual dialogue (they speak in Spanish and the patients speak in Catalan) in order to facilitate communication.

"The fact is that whenever a patient comes in speaking Catalan, I speak to them in Spanish and if they try to speak to me in Spanish, I always say 'No, please, don't. Speak to me in Catalan'. The ideal situation is for them to express themselves in the way they are naturally most comfortable." (D6.M.CV.NB)

"In my case I always speak in Spanish, because where I am, Valencian is practically not spoken." (E4.F.CV. NB)

b. The health professional's mother tongue is Spanish and, although they know Catalan, they are not willing to switch and do not allow the patient to speak to them in Catalan (even though this can seriously hamper communication).

"I am totally bilingual, but I am more fluent in Spanish (...) patients have the right to speak in the language they want, but I don't know to what extent. I don't know if we [doctors] have any more duty than the patient to communicate in a particular language. They don't shift language even if you don't tell them that you can speak Valencian [Catalan]. I don't know if it is an issue of the patient being rude, it is an issue of adoption of rights, that the patient considers that you are obliged to speak in another language. And you are not obliged to, and if the patient is sensible enough, he sees that you are a Spanish speaker and I think he must make a little effort (or speak in Spanish)." (D4.M.CV.B but not a regular Catalan speaker)

c. The health professional's mother tongue is Catalan, and they always initiate communication in this language, but they are willing to switch to Spanish if needed for the sake of better communication.

"I am a Catalan speaker, but I think we should let the patients express themselves in their own language. Even if you are not a Catalan speaker, it is important to let the patient explain it to you in their own language so that you can understand them better. (. . .) "I try to adapt to the language in which they are expressing themselves. I try to give them the possibility to explain it to me, because there are symptoms that are better explained in their mother tongue. There is no problem, there is bilingualism, everyone lives with both languages. But there are patients, especially older people and those who live inland, who express themselves better in Valencian [Catalan]." (D1.M.CV.B)

"I try to ask the first time I meet the patient whether they prefer to be spoken to in Spanish or Catalan. If you speak to them in their mother tongue, they feel more relaxed and communication flows better. (. . .) I also think it is important to communicate with patients in their mother tongue. Anybody expresses themselves best in their mother tongue; it is the way they feel most comfortable, above all it is the formula for them to relax." (D2.F.CV.B)

> "At the beginning (of the encounter) I speak Catalan, but as soon as I detect that they speak in Spanish I switch (to Spanish) (. . .) I don't find it difficult to change and adapt to them." (E1.F.CV.B)
>
> "In the end, what you want (as a health professional) is for them to understand you and show closeness." (E2.F.CV.B)
>
> "I, like her, feel closer to the patient by speaking Valencian (Catalan), as my parents have taught me, and I kind of transmit more affection, but I don't mind shifting." (E5.F.CV.B)

d. The health professional's mother tongue is Catalan, but they always start communication in Spanish and only decide whether to switch to Catalan depending on the development of the exchange.

> "It's the opposite for me (...) I always speak in Spanish so that there is no (factual) mistake, and if someone from the villages speaks Catalan, then I switch to it." (E3. F. CV. NB)

As we can observe, the most frequent scenario is c, i.e., the health professional's mother tongue is Catalan, and they always initiate communication in this language, but they are willing to switch to Spanish if needed for the sake of better communication.

These four scenarios may respond to different factors. Most of the participants whose mother tongue is Catalan reported that they adapt to the patient's language without any problems, either because they have linguistic ability in Spanish and Catalan or because of their sense of empathy with the patients.

> "I think that if someone does not speak the language used by the patient it is because she does not have a good command of it, that is, many times a patient speaks in Valencian (Catalan) and the health worker answers to her in Spanish because the professional does not know it. However, I think that it conveys more closeness to answer the patients in the language in which they speak to you." (E6.F.CV.B)

However, other participants did not show such a positive attitude due to a variety of possible reasons. They may not have mastered the minoritized official language (Catalan); they may not have been aware of its legal status; they may have been reluctant or unwilling to deal with patients speaking Catalan; or, finally, they may not have thought that language choice is a relevant factor in communication.

> "I'm Basque, I worked in Catalonia and now I work in the Valencian Community. I find a big difference between working in Catalonia and the Valencian Community, the permissiveness that exists in the Valencian Community is not found in Catalonia in general, I was given deadlines to learn Catalan. My conclusion is that language [choice] does not limit communication with the patient, it has never limited me if the patient has wished to communicate with me (regardless of the language), (but) if they have not wished to communicate with me, yes it [their attitude] has limited communication." (D5.M.NCV. NB)
>
> "In the consultation, in the end the responsibility for lack of communication is shared (by doctor and patient)." (D3.F.NCV.NB)

The question of the language of care (Catalan or Spanish) was not a theme that appeared spontaneously in the nurses' discussion, nor was it raised as an issue, nor did it generate tensions between the members participating in this focus group. In all cases, the participants considered that the priority is for the patient to feel comfortable and to express themselves in their own language. Regardless of their mother tongue, five nurses are fluent in both languages, although for one of them the Catalan is not the language she uses regularly. The other two nurses are monolingual Spanish speakers.

> "I think it conveys more closeness to answer them in the language they speak to you." (E6.F.CV.B)

> "Most of us [nurses] can speak both languages, so it's not usually a problem. Although obviously one is always more comfortable speaking one language or the other, it's not a problem to switch." (E7.F.CV.B)

The question of the language of care (Catalan or Spanish) did appear spontaneously in the debate among medical staff, and a certain tension was observed, because opposing positions emerged. Regardless of their mother tongue, four doctors are bilingual, although for two of them, Catalan is not the language he uses regularly, and three doctors are monolingual Spanish speakers (one of them born in the Valencian Community). In some cases, in our opinion, a prejudice was assumed that goes against the most basic ethical principles of respect for patient autonomy (D4.M.CV.B, for example; see above).

4. Final Remarks and Conclusions

Returning to our initial research question, we can start answering it by saying that perceptions of professionals in relation to the importance of the patient's mother tongue in situations of asymmetrical social bilingualism vary a great deal, are complex, and seem to form a continuum ranging from more positive to more negative judgements.

Different values are represented in the participants' perceptions, ranging from respect for and full alignment with the patient's perspective to negative opinions. On the positive, patient-centered side, professionals express a variety of reasons to let patients speak in their mother tongues—whether Catalan or Spanish—such as facilitating understanding, making them feel more comfortable, building rapport with them, or allowing them to express their experiences in a better, more meaningful way. On the negative side, professionals question the patients' rights to speak in their mother tongue or think that language is a non-factor in clinical communication. These negative views reflect a lack of awareness of the role of languages in clinical communication. Both can and should be considered in the acquisition of cultural competence. It is worth noting that, in our study, these negative perceptions refer to patients speaking Catalan. Thus, in the analyzed situation, linguistic and cultural asymmetries seem to be reinforced to the detriment of the patient.

This exploratory study suggests that the differences observed between nurses and doctors perhaps may be due to their training and their professional role and identity. According to data collected in our Focus Groups, Nurses seem to be more patient-centered and more concerned with illness and the human aspects of care, whereas some doctors are less patient-centered, perhaps due to the fact that they have been trained to be more disease-oriented and biomedically competent and less culturally and linguistically aware in the way they interact with patients. This aspect should be further researched to find out whether nurses and doctors really have different outlooks on the role and importance of the patients' mother tongues.

Among the fundamental issues that must be considered for the success of communication in clinical settings is the ability of the healthcare professional to understand the relevance of using the patient's mother tongue, whether the professional knows it and uses it normally or not, and whether the patient's mother tongue is dominant or minoritized. This is a particularly complex issue in the case of communities with two official languages, such as Catalan and Spanish in the context of our study, in which patients whose mother tongue is Catalan face a double asymmetry—intralingual and interlingual—within the same ethnic/national context. Some of the scenarios provided by the participants can be useful in the acquisition of this aspect of cultural competence. For example, promoting bilingual interactions in Catalan and Spanish could help in terms of bridging gaps and redressing linguistic and cultural asymmetries. The use of roleplays in educational contexts where cultural competence is taught and learned can be a solution. Roleplays can provide the kind of contextual, experiential, and reflective learning required not only for bilingual interactions but also for other communication skills such as code-switching or encouraging the patient to speak her/his mother tongue, when it is a minoritized language in diglossic clinical contexts.

Drawing on the results of this exploratory study, we think there is a need to train medical and nursing students and professionals to ensure that patients can express themselves in their mother tongues. An institutional strategy of training in communication skills and competences starting in the medical and healthcare schools is necessary. This institutional strategy should also include raising awareness among the professional communities through public policies and recommendation to health professionals. Future medical translators and interpreters should also be included in this strategy to build a culturally competent healthcare system.

This research focused on IC, a highly formalized genre with a strong medico-legal dimension and function. Further research, both qualitative and quantitative, should address the role of the patient's mother tongue in other genres and communicative situations in clinical contexts.

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Data Availability Statement: Data available on request due to restrictions (e.g., privacy or ethical). The data presented in this study are available on request from the corresponding author. The data are not publicly available due to the need to preserve privacy of the participants in the recorded online focus groups. Anonymized transcriptions of the focus groups are available on request.

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