

5-3-1989

# Designing an Instructor's Manual for Introducing Cultural Concepts in the Medical School Curriculum

Barbara C. Nicodemus  
*Portland State University*

Follow this and additional works at: [https://pdxscholar.library.pdx.edu/open\\_access\\_etds](https://pdxscholar.library.pdx.edu/open_access_etds)



Part of the Bilingual, Multilingual, and Multicultural Education Commons, and the Social and Cultural Anthropology Commons

Let us know how access to this document benefits you.

---

## Recommended Citation

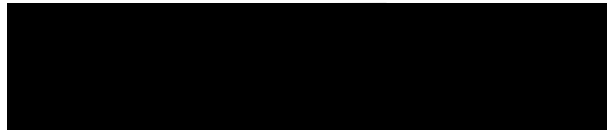
Nicodemus, Barbara C., "Designing an Instructor's Manual for Introducing Cultural Concepts in the Medical School Curriculum" (1989). *Dissertations and Theses*. Paper 3898.  
<https://doi.org/10.15760/etd.5782>

This Thesis is brought to you for free and open access. It has been accepted for inclusion in Dissertations and Theses by an authorized administrator of PDXScholar. Please contact us if we can make this document more accessible: [pdxscholar@pdx.edu](mailto:pdxscholar@pdx.edu).

AN ABSTRACT OF THE THESIS OF Barbara C. Nicodemus for the  
Master of Arts in Anthropology presented May 3, 1989.

Title: Designing an Instructor's Manual for Introducing  
Cultural Concepts in the Medical School Curriculum

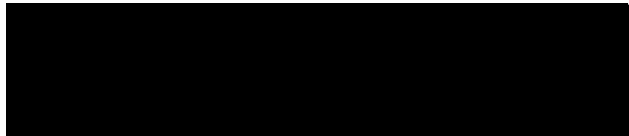
APPROVED BY MEMBERS OF THE THESIS COMMITTEE:



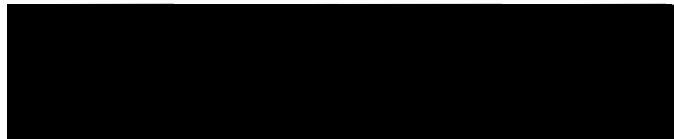
Jacob Fried



Daniel J. Scheans



Sharon Carstens



Harold C. Jorgensen

Medical educators recognize the need for including  
cultural insights into the training of future physicians.  
This instructor's manual suggests selected journal articles  
and guidelines for their use in each of the clinical courses  
to illustrate the relevance of culture, inter- and  
intraethnic differences, an attitude of cultural relativity,

and the importance of language use and communications skills for medical practice. The articles are found in journals typically available to medical students. This manual provides a baseline integrative approach applicable to other specialized training programs. A recommendation is made for evaluation and revision of history-taking interview forms to elicit additional culture-specific information. It is argued that an increase in physicians' cultural sensitivity and a decrease in medicocentrism will improve patient care.

DESIGNING AN INSTRUCTOR'S MANUAL FOR INTRODUCING  
CULTURAL CONCEPTS IN THE MEDICAL SCHOOL CURRICULUM

by

BARBARA C. NICODEMUS

A thesis submitted in partial fulfillment of the  
requirements for the degree of

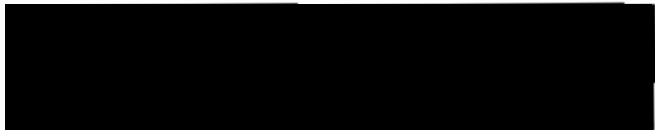
MASTER OF ARTS  
in  
ANTHROPOLOGY

Portland State University

© 1989

TO THE OFFICE OF GRADUATE STUDIES:

The members of the Committee approve the thesis of  
Barbara C. Nicodemus presented May 3, 1989.



Jacob Fried



Daniel J. Scheans

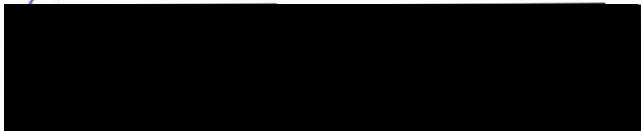


Sharon Carstens

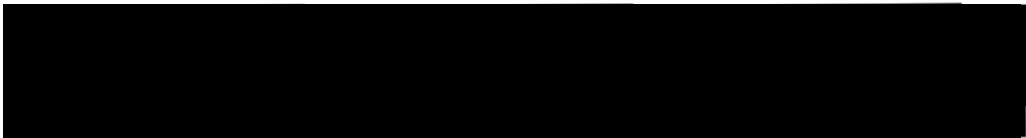


Harold C. Jorgensen

APPROVED:



Marc R. Feldesman, Chair, Anthropology Department



Bernard Ross, Vice Provost for Graduate Studies

## TABLE OF CONTENTS

	PAGE
INTRODUCTION.....	vi
Purpose of the Manual.....	vi
Review of the Literature.....	vii
Methodology.....	viii
Design of the Manual.....	ix
 <b>AN INSTRUCTOR'S MANUAL FOR INTRODUCING CULTURAL CONCEPTS IN THE MEDICAL SCHOOL CURRICULUM</b>	
OVERVIEW FOR INSTRUCTORS.....	1
Introduction.....	1
Brief Discussion of Key Issues.....	1
Definitions and Function of Culture	
Impact of Inter- and Intraethnic	
Differences	
Definition and Function of the	
Principle of Cultural Relativity	
Language Use and Communication Styles	
as the Keys to Cross-Cultural	
Medical Practice	
CULTURAL ISSUES IN INTERNAL MEDICINE.....	7
Illustrative Case.....	7
Key Issues.....	7
Suggestions for Reading and Discussion.....	8
Etiological Beliefs	
Choices in Health Care Methods	
Impact of Life Style Choices	
Individuality of the Patient	

	PAGE
References for Cited Readings.....	11
CULTURAL ISSUES FOR SURGEONS.....	12
Illustrative Case.....	12
Key Issues.....	13
Suggestions for Reading and Discussion.....	14
Contamination Beliefs	
Contrasting Perceptions of Pain	
Communication Styles	
Role Expectations	
References for Cited Readings.....	17
CULTURAL ISSUES IN PEDIATRICS.....	18
Illustrative Case.....	18
Key Issues.....	19
Suggestions for Reading and Discussion.....	20
Parent-Child Relationship	
Traditional Medical Treatments Used	
by Parents	
Adult Body Imagery	
Food Beliefs	
References for Cited Readings.....	24
CULTURAL ISSUES IN OBSTETRICS AND GYNECOLOGY.....	25
Illustrative Case.....	25
Key Issues.....	26
Suggestions for Reading and Discussion.....	27
Medicalization of Women	
Contrasting Views of Natural Functions	
Social Structuring of Post-Partum Events	
Folk Models of Role Transitions	
References for Cited Readings.....	31

	PAGE
CULTURAL ISSUES IN PSYCHIATRY.....	32
Illustrative Case.....	32
Key Issues.....	33
Suggestions for Reading and Discussion.....	34
Development of Psychobiomedical Profession	
Definitions of Causation	
Religious and Political Ideologies	
Context of Therapy	
References for Cited Readings.....	39
CULTURAL ISSUES IN FAMILY PRACTICE.....	40
Illustrative Case.....	40
Key Issues.....	41
Suggestions for Reading and Discussion.....	42
Contrasting Views of the Physician- Patient Relationship	
Patient-Family Relationship	
Patient's View of His/Her Chronic Illness	
Traditional Medical Treatments Used by the Patient	
References for Cited Readings.....	45
CONCLUSIONS.....	46
SOURCES CONSULTED.....	48
APPENDIX.....	54



## INTRODUCTION

The goal of this thesis in Applied Anthropology is the design of a manual with which medical school instructors can increase their students' awareness of the impact of cultural variables in the need for, and provision of, health care.

The manual is composed of small modules which might be offered within the standard clinical curriculum. Including these modules throughout all the respective clinicals would help to impress upon the student the underperceived role of cultural factors in the health:sickness paradigm.

## PURPOSE OF THE MANUAL

The Association of American Medical Colleges' Project Panel on the General Professional Education of the Physician and College Preparation for Medicine Report (GPEP Report) of November, 1984, strongly encouraged medical school curriculum planners and instructors to include more training in the humanities and behavioral sciences in the education of future physicians (GPEP:66-7; 70-2; 184-5). The lack of training in these areas directly affects the future physician's ability to diagnose, to cure, and to facilitate the maintenance of patients' health and well being (GPEP:

70-2).<sup>1</sup> The development of the future physician's personal and professional attitudes, demeanor, and ethics could also be enhanced by cultural insights (GPEP:66-7; 184-5).

This manual does not attempt to address all the possible ways in which these deficiencies might be corrected. However, during my interviews with a member of the committee charged with curriculum evaluation and revision in the School of Medicine of the Oregon Health Sciences University, it was clear that the medical educators would welcome suggestions for implementing changes in the curriculum which could provide an understanding of the role of culture in the physician:patient relationship.<sup>2</sup>

#### REVIEW OF THE LITERATURE

The AAMC Project surveyed 126 medical schools in the United States and Canada; only four require any anthropology or ethnology at the premedical school level (GPEP:111). Well before the GPEP Report was compiled, Kleinman et. al., were urging the medical profession to adopt lessons learned from cultural anthropology in both the training of

---

<sup>1</sup>Personal communication, Karen Deveney, M.D., Associate Professor of Surgery, Director, Surgical Education, Oregon Health Sciences University, Portland, OR.; and, Walter C. Reynolds, M.D., Physician and Surgeon, Phil Reynolds Medical Clinic, Portland, OR.

<sup>2</sup>Personal communication, Karen Deveney, M.D., Associate Professor of Surgery, Director, Surgical Education, Oregon Health Sciences University, Portland, OR.

physicians and in the practice of medicine (Kleinman et. al. 1978:251). Short term elective courses or seminars have been designed for use in addition to regular curricula (Bickel 1987; Mao et. al. 1988; Nurge 1975; Sundance et. al. 1985; Wells et. al. 1985). However, medical educators are in agreement that adding to the medical school curriculum in terms of time for additional courses is economically unfeasible (GPEP:198; McGuire et. al., 1983:28-9).<sup>3</sup> They also concur that medical students should be encouraged to develop independent, life-long learning skills utilizing professional journals and computerized professional databases (GPEP:5, 149-54; McQuire et. al., 1983.:241). Although only four of the schools surveyed use the problem-based learning module format (GPEP:38), the GPEP Report strongly urges an increased use of this pedagogical method (GPEP:121). To date, there have been no reports of an integrative approach which meets these criteria.

#### METHODOLOGY

An analysis of the basic medical school curriculum suggests that an introduction of the concepts of culture and cultural relativity may be most useful for the students during the clinical phase. This conclusion was affirmed in my discussions with a medical school educator and a

---

<sup>3</sup>Ibid.

practicing physician.<sup>4</sup> A library search for materials for this manual was conducted with the aid of computerized databases and published indices focusing only on journals most readily available to medical educators and students.

#### DESIGN OF THE MANUAL

The portion of this manual designed for students is based solely on materials available in professional journals. The use of only journal materials offers tangible benefits: (1) no additional text expense is required; (2) the student becomes acquainted with a wide variety of professional journals and approaches used by other, related fields; (3) selections can be continually updated and can be focused on various populations which the future physician will serve in North America; and, (4) most of the suggested readings are from psycho-biomedical journals and do not require either the instructor or the student to become fluent in the technical language of cultural anthropologists.

The major drawback to this approach is the limited range of material offered to students. Such a limitation may be corrected by maintaining supplementary texts on reserve for students' use. Such supplementary texts might include Eisenberg and Kleinman (1981); Harwood (1981); Moore

---

<sup>4</sup>See footnote 1.

et. al. (1980). Instructors might also wish to have The Western Journal of Medicine, Vol. 3, No. 9 (1983) placed on reserve status; this issue is devoted entirely to cross-cultural medicine and surveys a variety of cultural populations found in North America.

The journal articles selected for use in this manual represent a sample of the cultural variables which can affect any medical practice. Each of the modules focus on cultural issues relevant to an individual clinical practicum but these issues are not exclusive to only that field of medicine.

Each module for the clinical curriculum contains: (1) a brief overview of the importance of the particular cultural issues illustrated by the journal articles; (2) learning objectives; (3) suggestions for reading and discussion; and, (4) a list of the cited references for that module. Each module also includes one or two suggestions for student projects which can be used as the basis for problem-based learning. Most of these projects focus on communication skills which are fundamental to diagnosis, treatment and compliance.

A final word. This manual is not designed to provide a "how-to" approach for treating patients from any specific cultural group. Intraethnic differences make this approach impractical and theoretically inconsistent. Students can be encouraged to make use of the key words which most of the

articles contain to search the computerized databases or published indices for further information on the characteristics of the patient's cultural group. Such information can then be considered in the treatment of the individual.

AN INSTRUCTOR'S MANUAL FOR INTRODUCING  
CULTURAL CONCEPTS IN THE MEDICAL SCHOOL CURRICULUM

Notes to the Instructor:

AN INSTRUCTOR MAY USE ANY ONE OR MORE OF THE  
UNITS INCLUDED IN EACH MODULE TO INCREASE THE  
STUDENT'S AWARENESS OF THE IMPACT OF CULTURE ON  
THE PRACTICE OF MEDICINE.

The units may be also distributed over the  
duration of the clinical practice for each field  
or discussed during a single class meeting.

## OVERVIEW FOR INSTRUCTORS

### INTRODUCTION

This chapter provides a brief review of the theoretical issues illustrated by the articles suggested for student reading and discussion. The references included in the following units are offered to assist the medical instructor who wishes to increase his or her own understanding of the relevance of the concepts of culture and cultural relativity to medical education and practice. Foremost among the issues presented in this manual are:

#### **DEFINITIONS AND FUNCTION OF CULTURE**

#### **IMPACT OF INTER- AND INTRAETHNIC DIFFERENCES**

#### **DEFINITION AND FUNCTION OF THE PRINCIPLE OF CULTURAL RELATIVITY**

#### **LANGUAGE USE AND COMMUNICATION STYLES AS THE KEYS TO CROSS-CULTURAL MEDICAL PRACTICE**

#### **BRIEF DISCUSSION OF KEY ISSUES**

#### Definitions and Function of Culture

In the Western biomedical model, "disease" is seen as an empirically verifiable dysfunction in either biologic or psychologic processes of humans. However, "illness", from an anthropological perspective, is a culture-bound domain of



explanation and behavior associated with any perceived abnormality in either of these processes. If a condition is not perceived as dysfunctional or does not represent a disvalued mental or physical state, it will not require a "cure" regardless of the bio/psychomedical evidence to the contrary (Kleinman et. al., 1978:251-2). The converse is also true. If a condition is perceived as dysfunctional or disvalued it will be identified as an "illness" even though this condition cannot be confirmed empirically by medical science as "pathological".

A physician's understanding of "sickness," defined as the process by which individuals and groups socialize those conditions perceived as "illness" or "disease" (Young 1982:270), requires some technical understanding of the anthropological concept of culture. Minimally, culture is a learned, shared, patterned, symbolic way of life developed by a human group by which they respond to their physical and social environment (Angel and Thoits 1987; Keesing 1974; Moore et. al. 1980; Rohner 1984).

#### Impact of Inter- and Intraethnic Differences

The manner in which individuals and groups perceive, act out, and treat the "sick role" differs within sub-categories of a single cultural group, and between different cultural groups. Studies of such interethnic and intraethnic differences and their importance include: Clark (1983); Eisenberg (1977); Goodenough (1978); Kleinman

(1974); and, Pelto and Pelto (1975). The range of differences among cultural groups is similar to that found within and between biologically defined groups. A recognition of the perceptions and values that shape a cultural group's health-related behavior can be helpful in improving the efficacy of medical treatment. Helping medical students understand that such behaviors and values including the bio/psychomedical model itself, are culturally based, is a needed first step in developing cultural sensitivity in the practice of medicine (Eisenberg ibid; Kleinman ibid; Pfifferling 1981).

#### Definition and Function of the Principle of Cultural Relativity

Decreasing ethnocentrism and "medicocentrism" is the goal of exposing the medical student to the concept of cultural relativity which begins with the understanding that the particular beliefs and behaviors of any cultural group are valued by, and valid for, the members of that culture; but in a multi-cultural world, this means each group lives in a different world of meaning and behavior (Herskovits 1972:88). Herskovits' statement of cultural relativity has posed theoretical problems for both anthropologists and philosophers because it can be interpreted as suggesting that the specific American cultural value of tolerance is in fact the overriding principle behind this "scientific" approach of non-judgmental observation. Even if the premise

would be acceptable, tolerance of cultural differences does not imply open-ended acceptance of, and paralysis in the face of, another group's beliefs and behaviors which are antithetical to one's own. Despite such differences of position, the anthropologist, the philosopher, and the physician, can agree that cultural differences arise from the subtle, almost unconscious manner in which group values and behavior patterns are developed and learned by individual members of the group and, in turn, are transmitted to the next generation. Differing cultural values and behaviors can be understood as valid and worthy to the group that maintains and utilizes them to relate to their psychological and physical environment (Renteln 1988).

Culturally-bound frameworks of perception of what constitutes health:disease:illness arise and continue in response to varying historical and environmental conditions. If there is no firm identification of what are culture-free, universal values (something that has continued to elude both anthropologists and philosophers alike) even in the realm of health issues, the Western biomedically-trained physician is left in a quandary as to how to understand and treat patients' symptoms, as well patients' responses to treatment programs when their points of view are in conflict. Since Western biomedicine presumes to operate from a posture of non-cultural, scientific objectivity, a countering influence concerning cultural relativism can provide the physician

with a more sensitive frame of reference in which the patient's needs can be accurately perceived and met more efficaciously. A physician does not have to personally agree with a patient's culture-bound beliefs and behaviors. However, in a pluralistic American society, all medical practice is cross-cultural in nature. Sensitivity to cultural differences is needed whether the patient and the physician come from the same socioeconomic or ethnic group or not. In devising treatments, it is neither compassionate nor practical to ignore the value the patient places on certain beliefs and behaviors.

In order to assist the medical student to arrive at a workable model for more sensitive objectivity in diagnosis and treatment, this manual focuses not only on those "other, exotic" cultural groups within North America, but also on mainstream, Anglo-American cultural groups, including physicians themselves as a professional sub-culture.

#### Language Use and Communication Styles as the Keys to Cross-Cultural Medical Practice

As indicated earlier, the modules suggested for use throughout the clinical phase of medical school do not provide specific solutions in any given medical situation. Instead, these modules provide illustrations of the cultural framework in which difficulties may arise in medical practice. The primary tools with which to overcome these difficulties in symptom presentation, diagnosis and

treatment for both the physician and the patient are verbal and nonverbal communication. Therefore, most of the modules suggest exercises to increase the communication skills of the student. The medical instructor may wish to refer to Berlin and Fowkes (1983), Harwood (1981:29), Kleinman et. al. (1978:56-7), Katon and Kleinman (1981:270-1), and Pfifferling (ibid:207) for specific examples of interview techniques. Their models incorporate the recognition that cultural differences affect the patient:physician relationship and cognitive structuring of symptoms. These models can be used as guidelines to develop and evaluate students' communication skills and professional attitudes. For the convenience of the instructor, the Appendix presents these interview models and techniques.

Further, these interview models can provide the basis for an evaluation and possible revision of the various medical patient history-taking forms currently in use. Adding questions suggested by these models to the present interview form to elicit culture-specific information can improve the physician's understanding of the patient's perception of their own illness and provide further clues helpful to the physician in negotiating an appropriate treatment program.

## CULTURAL ISSUES IN INTERNAL MEDICINE

### ILLUSTRATIVE CASE

**Rx:** Eat a greasy hamburger before a "night on the town" so you can drink with impunity. Or, take aspirin before going to bed if you've had a lot to drink. This will prevent the morning-after headache.

**Rx:** Throw a dead cat over a tree limb in the light of a full moon to get rid of warts.

**Rx:** To reduce the risk of heart disease, start your day with a bowl of high-fiber cereal and run or walk three miles a day.

What do these prescriptions have in common? They all represent just a few of the long-standing folk medical traditions still operative in North America. Medical students themselves may even subscribe to one or two of these beliefs.

### KEY ISSUES

This module is designed to help the student understand that although the physician and patient share a common language and similar cultural heritage, their cultural beliefs may differ significantly. An assumption of commonality ignores the importance of intraethnic differences and the consequences of life style choices which

individuals make. Some of the areas in which such contrasting assumptions may be operative are:

**ETIOLOGICAL BELIEFS**

**CHOICES IN HEALTH CARE METHODS**

**IMPACT OF LIFE STYLE CHOICES**

**INDIVIDUALITY OF THE PATIENT**

Recognizing intraethnic differences between physician and patient and among patients will help the physician to view the patient as a person, not merely as a category. This attitude will increase the effectiveness of treatment programs.

**SUGGESTIONS FOR READING AND DISCUSSION**

Etiological Beliefs

Required readings: Chino and Vollweiler (1986) and Zola (1966)

Beliefs about illness causation vary among middle-income Anglo-Americans as reported by Chino and Vollweiler. The variation is no less than that found 20 years earlier by Zola's study of Italian and Irish patients.

As an exercise, the instructor might have students design treatment strategies for similar symptoms among individuals with different causation beliefs.

Or, students could be required to construct an interview designed to elicit a patient's illness beliefs relative to their presenting symptoms.

### Choices in Health Care Methods

Required readings: Whorton (1987) and Snyder (1981)

Students should read Whorton's discussion of the traditions of folk medicine, and then Snyder's article for an appreciation of the long-standing popularity and reliance on such methods of treatment in the lay population. Snyder also points out how such healing methods are used by ethnically different populations.

Students might compare the folk medicine which they learned as children and discuss the rationale for the continuation of such practices in the presence of biomedical alternatives.

### Impact of Life Style Choices

Required readings: Troyer (1988) and Tryoler and Cassel (1964).

Have students read these articles for an appreciation of the consequences which individuals' choices in life styles have on their health. Troyer presents evidence that adherence to specific religious directives which preserve a particular life style can both prevent and contribute to disease. Sociocultural changes prompted by economic needs can, as Tyroler and Cassel illustrate, increase an individual's vulnerability to disease.

The instructor might present a set of symptoms which would reflect difficulties physicians might face in negotiating a treatment program which may run counter to the



religious directives of an individual, i.e., in terms of diet.

### Individuality of the Patient

Required readings: Lin (1983) and Hahn (1982)

Stereotypic thinking results in a depersonalization of physician:patient relationships and can contribute to mutual dissatisfaction. Borrowing from Lin's family practice experiences, the student can recognize the frustration the physician may feel when the patient does not conform to their expectations. Have students then read and discuss Hahn's description of physicians' practice of stereotyping a patient as the syndromes they present for treatment.

Students might be asked to suggest ways in which the history-taking interview form used in internal medicine might be adapted to include information which would assist them in avoiding stereotyping their patients so that the "person" of the patient can be more fully considered in diagnosis and treatment.

**The instructor may wish to refer to the Appendix for suggested questions and interview techniques which could form the basis for eliciting patients' culture-bound beliefs and behaviors regarding health issues.**

## REFERENCES FOR CITED READINGS

- Chino, Harriet and Lothar Georg Vollweiler  
1986 Etiological Beliefs of Middle-Income Anglo-Americans Seeking Clinical Help. Hum. Org. 45(3):245-254.
- Hahn, Robert A.  
1982 Treat the Patient, Not the Lab: Internal Medicine and the Concept of "Person". Cult. Med. Psychiatry 6(3):219-236.
- Lin, Elizabeth H.  
1983 Intraethnic Characteristics and the Patient-Physician Interaction: "Cultural Blind Spot Syndrome". J. Fam. Pract. 16(1):91-8.
- Snyder, Patricia  
1981 Ethnicity and Folk Healing in Honolulu, Hawaii. Soc. Sci. Med. 15B:125-132.
- Troyer, Henry  
1988 Review of Cancer among 4 Religious Sects: Evidence that Life-Styles are Distinctive Sets of Risk Factors. Soc. Sci. Med. 26(19):1007-1017.
- Tryoler, H. A. and John Cassel  
1964 Health Consequences of Culture Change - II. The Effect of Urbanization of Coronary Heart Mortality in Rural Residents. J. Chron. Dis. 17:167-177.
- Whorton, James C.  
1987 Traditions of Folk Medicine in America. JAMA 87:1632-36 (3/27/87).
- Zola, Irvin Kenneth  
1966 Culture and Symptoms - An Analysis of Patients' Presenting Complaints. Am. Soc. Rev. 31:615-630.

## CULTURAL ISSUES FOR SURGEONS

### ILLUSTRATIVE CASE

Surgical procedures can be accepted as an effective, mechanistic way of repairing physical dysfunction and that generally these procedures take place in a "sterile" environment. However, for certain Southeast Asian patients, such surgical procedures would allow the spirit to escape the body and thus death can ensue. On the other hand, for Gypsies, entering a hospital and undergoing the surgical removal and subsequent disposal of dysfunctional body parts creates serious spiritual problems. According to their religious beliefs, Gypsies cannot enter heaven unless they have a "whole" body, including all nail and hair clippings. They must somehow "buy back" any missing body parts. Further, a non-Gypsy represents a source of ritual pollution which can endanger a Gypsy's soul. This sense of danger is heightened in a hospital setting where the vulnerable, lone Gypsy patient is surrounded by non-Gypsies and their "polluting" practices. One Gypsy patient will have many round-the-clock visitors. Gypsy religious beliefs require strict separation of all items which come in contact with genitalia from items which do not; hospital laundries are not set up to accommodate this religious belief. Gypsies also maintain individual eating utensils and these must not

come into contact with those used by pregnant or menstruating women. Likewise, for Gypsies, the lower portion of the body, waist to ankles, must be carefully concealed; the standard hospital gown does not meet this important religious dictate.

#### KEY ISSUES

Once a patient agrees to surgery and enters the hospital setting, the relationship between the physician, the nurse, and the patient is frequently unsatisfactory. This module helps the surgeon recognize some of the cultural issues which can influence the patient's reluctance to submit to surgery as well as their post-operative behavior. Among such issues are:

**CONTAMINATION BELIEFS AND RITUALS**

**CONTRASTING PERCEPTIONS OF PAIN**

**COMMUNICATION STYLES**

**ROLE AND EXPECTATIONS**

Understanding how these cultural issues influence the behaviors of both the physician and the patient in the hospital can provide clues to ways the physician can ameliorate the tension between the patient and him/herself.

## SUGGESTIONS FOR READING AND DISCUSSION

Contamination Beliefs

Required readings: Thomas (1985), Wetzel et. al. (1983),  
and Katz and Kirkland (1988)

Have students read Thomas and Wetzel et. al. with a view to understanding the reluctance of this ethnic group to permit hospitalization, especially for surgical procedures. The concept of marimé, or spiritual and life-threatening contamination by contact with non-Gypsies, especially non-Gypsy hygiene practices, contributes to their reluctance to seek surgery. Gypsies must also regain all lost body parts before entering heaven. Students should then read Katz and Kirkland's discussion of the rationale for the hygiene rituals practiced in the hospital.

The instructor might wish to have students discuss (1) the psychological function of rituals for both the physicians and the Gypsies, and (2) the effects contrasting views of contamination have on the physician:patient relationship.

Contrasting Perceptions of Pain

Required reading: Lipton and Marbach (1984)

Although this article deals with patients with facial pain, the students should be able to apply this perspective to the surgery patient's reports of pain. Have students discuss their feelings about the appropriateness of expressions of pain on both an ethnic and gender level.

As an exercise, the instructor might wish to have students log patients' descriptions of pain and note which expressions prompted a modification in their attitude and treatment of the patient.

### Communication Styles

Required reading: Bourhis, Roth and MacQueen (1989)

Language and communication styles incorporate status and power differences. Each social setting has a vocabulary and communication style all its own. The hospital is no exception. Students should read this article which suggests that physicians can produce a more satisfactory patient:physician relationship by using everyday language when speaking with patients.

The instructor may wish to use an analogy of the student's discomfort and confusion when they first entered medical school and encountered medical terms and the patients' experience in the hospital setting.

### Role Expectations

Required reading: Hartog and Hartog (1983)

The roles of both the physician and the patient are culturally-based. When these behaviors do not conform to the expectations of one another, patient care and recovery can suffer.

Students should read this article and discuss their own expectations of patient behavior in specific situations

to see where their own expectations can negatively affect patient recovery. A group discussion of the students' behavioral expectations can help them see where and how accommodations might be made in the hospital.

**The instructor may wish to refer to the Appendix for suggested questions and interview techniques which could form the basis for eliciting patients' culture-bound beliefs and behaviors regarding health issues.**

## REFERENCES FOR CITED READINGS

- Bourhis, Richard Y., Sharon Roth, and Glenda MacQueen  
1989      Communication in the Hospital Setting: A Survey  
          of Medical and Everyday Language Use Amongst  
          Patients, Nurses and Doctors. Soc. Sci. Med.  
          28(4):339-346.
- Hartog, Joseph, MD. and Elizabeth Ann Hartog, RN, MA  
1983      Cultural Aspects of Health and Illness Behavior  
          in Hospitals. West. J. Med. 139(6):910-916.
- Katz, Pearl and Faris R. Kirkland  
1988      Traditional Thought and Modern Western Surgery.  
          Soc. Sci. Med. 26(12):1175-1181.
- Lipton James A. and Joseph J. Marbach  
1984      Ethnicity and the Pain Experience. Soc. Sci.  
          Med. 19(12):1278-1298.
- Thomas, James D.  
1985      Gypsies and American Medical Care. Ann. Intern.  
          Med. 102(6):842-5.
- Wetzel, Randall C., J. Michael Dean and Mark C. Rogers  
1983      Gypsies and Acute Medical Intervention.  
          Pediatrics 72(5):731-5.



## CULTURAL ISSUES IN PEDIATRICS

### ILLUSTRATIVE CASE

Child abuse is a sensitive issue and takes many forms in today's world. Abusive behavior can exist in both the physical and psychological realms. However, were a Southeast Asian parent to neglect calling upon folk medical practitioners to perform moxabustion on a child with high fevers or abdominal pains, they, themselves, and members of their ethnic group, would consider them to be delinquent in their responsibilities as parents. The goal of moxabustion is to warm the body and increase metabolism; its origin lies in ancient Chinese medical practices. The traditional method of moxabustion is to burn cones or balls of an herb, mugwort, upon the skin at the culturally-defined point(s) where the pain or symptoms originate. Yarn has been used where mugwort is unavailable. Occasionally, lighted cigarettes have been substituted for mugwort. The burning causes circular scars and the scars are often patterned on the lower trunk below the rib cage, on the back, or around the umbilicus. Pediatricians have also reported moxabustion scars found on the buttocks of children (to treat enuresis) and between the thumb and forefinger (to treat temper tantrums). These treatments are consistent in cultures where emotional difficulties are not recognized in the

Western biomedical sense but are expressed in culture-specific somatic terms.

What does a physician, trained in the Western biomedical system, do when a child is presented for his or her care when the child has patterns of burn scars? Reporting the parents to the legal authorities has lead, in one case, to an arrest, incarceration, and subsequent suicide by a father whose shame and embarrassment at being accused of "not caring for his child" was too great to bear in his cultural system. What is a physician's responsibility to children when culturally-shaped adult beliefs and behaviors are considered to represent a threat to the mental and physical well-being of children, given the physician's medical training?

#### KEY ISSUES

An awareness of the impact of diverse belief systems is especially crucial in the practice of pediatrics. Children begin their enculturation the moment they are born. When in need of health care, they are literally at the mercy of the beliefs of their parents and the physicians. This module will help the pediatrician recognize some of the areas in which their cultural ideals for child care are at variance with the cultural ideals and practical realities of the parents. Among such issues in this ideal:real dichotomy are:

**PARENT-CHILD RELATIONSHIP****TRADITIONAL MEDICAL TREATMENTS USED BY PARENTS****ADULT BODY IMAGERY****FOOD BELIEFS**

A sensitivity to the child's cultural milieu will permit the pediatrician to structure negotiations for treatment with parents and the child.

**SUGGESTIONS FOR READING AND DISCUSSION****Parent-Child Relationship**

Required readings: Zeskind (1983) and Spinetta (1984)

Have students read Zeskind's article to sensitize them to the fact that although maternal reactions may vary cross-culturally in response to infants' crying, maternal interest in the well-being of the child is not diminished, merely culturally-specific in form. Students should then read Spinetta's discussion of the variation in parent-child relationships in the context of childhood cancer.

Communication patterns are culture specific. The students might be asked to design an interview protocol which will assist them to discover the parent(s)' communication patterns with their child. This exercise will help the physician to negotiate a continuation of treatment.

### Traditional Medical Treatments Used by Parents

Required readings: Redlener and Scott (1979), Feldman (1984).

The pediatrician may encounter traditional medical practices used by the child's family which (1) may present an ethical dilemma within the context of the physician's culture, and (2) may not appear efficacious from a biomedical point of view.

Redlener and Scott illustrate the consequences for a child and his family when the etiologic and treatment systems of the medical profession and the parents were not compatible. Have students discuss the practical recommendations made by Redlener and Scott after reading Feldman's descriptions of folk healing methods applied to children in many Southeast Asian cultural groups.

Since parents usually will do everything they can to restore a child's health, a physician can increase the efficacy of the biomedical treatment strategy by incorporating the folk system wherever it is not specifically contraindicated. Again, students can devise an interview to find out what other methods the parents may be using.

In those instances where ideologies are inflexible enough to preclude a negotiation for treatment by medical personnel, the physician might enlist the aid of an intermediary. An instructor might wish to assign the students the task of locating such intermediaries and

compiling a directory. This exercise would give them experience in locating assistance and will help them in similar situations in the future.

### Adult Body Imagery

Required readings: Feldman, Feldman, and Goodman (1988) and Swartz (1985)

Not all cultures have the same ideas of physical beauty. Students should read and discuss Feldman et al., for an appreciation of how cultural values are learned and acted upon by children, sometimes to the detriment of their health. Then have students read Swartz for a discussion of one of the culture-bound syndromes they may encounter in children.

As an exercise, students might be asked to review the children's cases they are working on during their clinicals to discover what other culture-bound syndromes might be present. Minimally, they should be able to identify some parental values and behaviors which, when adopted by children, result in health problems.

### Food Beliefs

Required readings: Koo (1984) and Freimer, Echenberg, and Kretchmer (1983)

Food beliefs are probably the most important in any culture. They are certainly the first learned by children, regardless of whether they are breast- or bottle-fed. Students should read Koo's discussion of the dual role of

food in Chinese culture. Then have students discuss the implications of differential availability of valued foods in populations experiencing environmental or social change as described by Freimer et. al.

Students' development of interviewing techniques to elicit at least a minimal amount of information from their patient's parents about preferred foods, and their relative importance in the child's family's diet, will help them to negotiate dietary changes as may be biomedically indicated.

**The instructor may wish to refer to the Appendix for suggested questions and interview techniques which could form the basis for eliciting patients' culture-bound beliefs and behaviors regarding health issues.**

## REFERENCES FOR CITED READINGS

- Feldman, Kenneth W.  
1984 Pseudoabusive Burns in Asian Refugees. Am. J. Dis. Child. 138(8):768-9.
- Feldman, W., E. Feldman and J. T. Goodman  
1988 Culture versus Biology: Children's Attitudes toward Thinness and Fatness. Pediatrics 81(2):190-194.
- Freimer, Nelson, Dean Echenberg and Norman Kretchmer  
1983 Cultural Variation - Nutritional and Clinical Implications. West. J. Med. 139(6):928-933.
- Koo, Linda C.  
1984 The Use of Food to Treat and Prevent Disease in Chinese Culture. Soc. Sci. Med. 18(9):757-766.
- Redlener, Irwin E. and Clarissa S. Scott  
1979 Incompatibilities of Professional and Religious Ideology: Problems of Medical Management and Outcome in a Case of Pediatric Meningitis. Soc. Sci. Med. 13B:89-93.
- Spinetta, John J.  
1984 Measurement of Family Function, Communication, and Cultural Effects. Cancer 53(5):2330-2338.
- Swartz, Leslie  
1985 Anorexia Nervosa as a Culture-Bound Syndrome. Soc. Sci. Med. 20(7):725-730.
- Zeskind, Philip Sanford  
1983 Cross-Cultural Differences in Maternal Perceptions of Cries of Low- and High-Risk Infants. Child Dev. 54(5):1119-1128.

## CULTURAL ISSUES IN OBSTETRICS AND GYNECOLOGY

### ILLUSTRATIVE CASE

Freed from the proscriptions against eating unnecessary calories during pregnancy, many Anglo-American new mothers enjoy those first-chocolate-in-a-long-time in the hospital. Then, her breast-fed infant is reported as having diarrhea. Folk traditions connect the two activities in a causal relationship. The chocolates go in the wastebasket and the new mother feels responsible for the change in the infant's gastrointestinal state.

Other new mothers, notably those whose cultural beliefs include a hot:cold dichotomy in nutritional practices, may refuse to even commence breast feeding because the foods which are required to restore her health produce unhealthy breast milk for the infant. For example, many Southeast Asian refugee women maintain a preference for culturally-defined humorally warm foods which they believe will replace blood lost during delivery, as well as restore body heat and energy. Such foods may include, but are not limited to, chili, salty fish and meat dishes, and wine steeped with herbs. These foods are often "luxury" foods and are associated with her special status during post-partum. The longer the mother can continue to eat these foods, the sooner her health will return. These foods are



also thought to provide newborns with the necessary humoral warmth for the first month.

In order to increase lactation, however, the mother is expected to turn to humorally cool foods one month after delivery, cutting short her own perceived recuperation. Even during the first month, most mothers believe breast milk "needs" to be supplemented with sugar water or rice paste. That breast milk is nutritionally insufficient is "evidenced" by the mortality rate of breast-fed infants in their homelands. Rather than risk the child's development, Southeast Asian mothers often turn to formula immediately and pursue their own dietary needs, knowing the child will become "fat and healthy" like American children.

#### KEY ISSUES

The reproductive physiology of women is a biological universal. However, the manner in which a woman's reproductive cycle is viewed is culture-specific and relates to the social roles between men and women. Some of the ways in which cultural differences are reflected in women's health care are:

#### **MEDICALIZATION OF WOMEN**

#### **CONTRASTING VIEWS OF NATURAL FUNCTIONS**

#### **SOCIAL STRUCTURING OF POST-PARTUM EVENTS**

#### **FOLK MODELS OF ROLE TRANSITIONS**

The ob/gyn physician's increased awareness of the role sociocultural factors play in the recognition, and adoption, of the sick role by women will permit diagnosis and treatment to more closely match the needs of the patient herself.

#### SUGGESTIONS FOR READING AND DISCUSSION

##### Medicalization of Women

Required readings: Cayleff (1988) and Johnson (1987)

Have students read Cayleff for a historical perspective of how gender ideologies have affected the development of a gender-specific biomedical specialty. Students should then read and discuss Johnson's assertion that premenstrual syndrome has arisen in Western cultures as a response to dissatisfaction with gender-role expectations.

As an exercise, the instructor may wish to have students reflect on lay terms, particularly adjectives, associated with various stages in the reproductive cycle. Such an exercise can heighten the student's awareness of the generally negative attitudes and labels associated with significant events in a woman's biological life.

##### Contrasting Views of Natural Functions

Required readings: Scott (1975) and Basker (1983)

Students should read these articles for an appreciation of the range of meanings attached to events related to child bearing. Have students read Scott's

illustration of how contrasting views of menses affect the practical relevance of its cultural significance. Basker presents a case in which the cultural values of the physician and the patient were discordant enough to lead to disengagement rather than patient care.

The instructor may wish to incorporate the values of any of the cultures described in these readings into a case study where a treatment mode must be designed by students. Using such an approach may permit an evaluation of the student's cross-cultural sensitivity and ability to evaluate a patient's needs in her own terms.

#### Social Structuring of Post-Partum Events

Required readings: Harkness (1987), Pillsbury (1978), and Fishman et. al., (1988)

Students should read Harkness' discussion of the culturally-specific behaviors and expectations of the post-partum period which, if modified in the U.S., could preclude the experience of depression for many women during this period. Pillsbury presents a look at how the post-partum period is handled by Chinese women. Students should then evaluate the consequences described by Fishman et. al., which adherence to post-partum traditions can have, especially for low-income women and children.

**If Harkness is not readily available to students, the instructor may wish to substitute Stern and Kruckman (1983).**

The birth of children varies in its culturally-constructed significance between cultures. A constant, however, are the new demands made upon the mother. Students might be asked to suggest ways, in the absence of an extended family structure, in which women might alleviate the frequency and severity of the "blues" without resorting to psychotropic medication, i.e., self-help groups. Encourage students to consider what role could ob/gyn physicians could play in such programs?

#### Folk Models of Role Transitions

Required readings: Lock (1982)

Have students read and discuss Lock's critique of the current clinical models of menopause and their variance from the textual interpretation of this phenomenon. This article might be examined in conjunction with Cayleff's discussion of influence of gender ideologies in medical practice.

As an exercise, students might be asked to interview women experiencing menopause with whom they come in contact during their clinical practicum. Particular attention should be paid to the way in which the patient, herself, describes the experience, i.e., does she use particular metaphors to characterize it in particular way? This exercise can help students increase their ability to provide treatment using the patient's own cognitive framework.

**The instructor may wish to refer to the Appendix for suggested questions and interview techniques which could form the basis for eliciting**

patients' culture-bound beliefs and behaviors regarding health issues.

## REFERENCES FOR CITED READINGS

- Basker, Eileen  
1983 Coping with Fertility in Israel: A Case Study of Culture Clash. *Cult. Med. Psychiatry* 7(2):199-212.
- Cayleff, Susan E.  
1988 'Prisoners of Their Own Feebleness': Women, Nerves and Western Medicine - A Historical Overview. *Soc. Sci. Med.* 26(12):1199-1208.
- Fishman, Claudia, Robin Evans and Eloise Jenks  
1988 Warm Bodies, Cool Milk: Conflicts in Post Partum Food Choice for Indochinese Women in California. *Soc. Sci. Med.* 26(11):1125-1132.
- Harkness, Sara  
1987 The Cultural Mediation of Postpartum Depression. *Med. Anth. Qtrly.* 1(2):194-209.
- Johnson, Thomas M.  
1987 Premenstrual Syndrome as a Western Culture-Specific Disorder. *Cult. Med. Psychiatry* 11:337-356.
- Lock, Margaret  
1982 Models and Practice in Medicine: Menopause as Syndrome or Life Transition? *Cult. Med. Psychiatry* 6:261-280.
- Pillsbury, Barbara L. K.  
1978 "Doing the Month": Confinement and Convalescence of Chinese Women after Childbirth. *Soc. Sci. Med.* 12:11-22.
- Scott, Clarissa  
1975 The Relationship between Beliefs about the Menstrual Cycle and Choices of Fertility Regulating Methods within Five Ethnic Groups. *Intl. J. Gyn. Obs.* 13:105-109.
- Stern, Gwen and Laurence Kruckman  
1983 Multi-Disciplinary Perspectives on Post-Partum Depression: An Anthropological Critique. *Soc. Sci. Med.* 17(15):1027-1041.

## CULTURAL ISSUES IN PSYCHIATRY

### ILLUSTRATIVE CASE

Picture the headlines: "Psychiatrist Wrestles with Witchcraft". Fanciful? Not really. Belief in witchcraft in North America is rising, as is belief in a variety of other spiritual modes of handling discordance between ideals and reality in daily life.

Characterizing psychological disturbances as caused by witchcraft can occur in many cultural groups. For example, in a case where an Anglo-American family relocated from a rural to an urban area in order to make a college education more accessible for the children, the stresses of acculturation prompted scapegoat behavior toward one of the daughters. She had decided to attend college in order to escape the disharmony and changing relationships within the family. In the scapegoat role, the daughter's behavior changed dramatically. The entire family transferred its attention to her college friends as the cause of her changed behavior. Although she had been diagnosed as paranoid-schizophrenic, hospitalized, put on a medication regime for two weeks, and then released, the patient and her family believed that she had been "hexed" by some of her college acquaintances. Their belief in "hexing" stemmed from the patient's friends' own admissions that they were trying to

influence her behavior and help her by using extrasensory communication techniques. Because these efforts followed a prank of putting a black spider on her door in order to scare her, the idea that witchcraft was being used was given greater credibility.

### KEY ISSUES

Psychiatrists are not alone in having to deal with these kinds of coping strategies. Biomedical physicians may often refer patients for psychotherapeutic counselling when biomedical procedures do not relieve the presenting symptoms, which, while expressed somatically, have no clearly identifiable physical causes.

Although the culture of any group or individual is continually changing, as demonstrated in the illustration above, group values change more slowly than do individual values and concomitant behavioral patterns. The various causes, manifestations, diagnoses, and treatments of behavior considered deviant are culture-bound and likewise subject to change. Psychiatric therapy, both biomedical and psychological, can be enhanced by a fuller appreciation of impact changes have on the individual and group. Among the realms in which such changes can occur are:

#### DEVELOPMENT OF PSYCHOBIOLOGICAL PROFESSION

#### DEFINITIONS OF CAUSATION



**RELIGIOUS AND POLITICAL IDEOLOGIES**  
**CONTEXT OF THERAPY**

A physician's awareness of the changes in individual and group values will provide a perspective from which he/she may more clearly design a therapeutic regimen.

**SUGGESTIONS FOR READING AND DISCUSSION**

Development of Psychobiomedical Profession

Required readings: Fabrega (1987) and Lopez and Hernandez (1986)

Have students read Fabrega for an appreciation of the difficulty inherent in divorcing the classification of mental illness from its sociocultural context. Lopez and Hernandez can then be read. Students should discuss the problems which Lopez and Hernandez illustrate can arise in diagnosis and therapy when an over-emphasis is placed on cultural factors which are not fully understood.

As an exercise, the instructor might assign students the task of constructing an interview protocol for use with other individuals with whom the patient is in frequent contact. Such an interview should be designed to elicit an understanding of just how the patient's behavior is viewed as pathological. This can help the physician to differentiate between biomedical and cultural pathogenesis.

### Definitions of Causation

Required readings: Pollock (1988) and Leininger (1973)

Definitions of any illness reflect ideologies of personal/group relationships. Pollock's discussion of the use of the concept of stress in Western medical traditions reflects the dichotomy between the concept of personal responsibility and individual lack of control in many social situations. Students should contrast "stress" with Leininger's description of the attribution of dysfunctional behavior to witchcraft practices.

Students might be asked to focus their discussions on how these different ideologies are related to the changing social order in which patients may find themselves, i.e., new jobs, increased responsibilities, changing social roles, acculturation pressures for both the individual and the group, etc.

### Religious and Political Ideologies

Required readings: Egeland et. al. (1983), Beiser et. al., (1989), and Gilman (1984)

The instructor may wish to assign any one or all of these readings to illustrate the impact of religious or political ideologies on the mental health of individuals.

Egeland et. al. focuses on the Amish, an evangelical Protestant sect that values simplicity of lifestyle and dress. Vocalization of inordinate pride is one behavior contradictory to this value system and is viewed as deviant,

requiring therapy. However, this article points out, diagnosis can be difficult if the physician looks only at the cultural-behavioral labels and ignores the biomedical pathogenic indices.

Beiser et. al., focus on the effects of involuntary migration necessitated by political events and the manner in which the Southeast Asian refugees cope with the consequences of these changes by altering their past-oriented concept of time and focusing on the present. They suggest that physicians should expect a recurrence of depressive symptomatology on anniversaries of significant events as the Southeast Asian patient returns to a culture-specific past orientation.

Political persecution and institutionalized prejudice because of religious ideology, particularly when it continues as long as it has for the Jewish people, can prompt a higher frequency of mental illness in such populations. Gilman examines the medical and lay metaphors associated with Jewishness and the manner in which Jews respond.

As an exercise for any of these readings, the instructor might wish to have the students focus their discussions on the importance of language as a symbolic, culture-specific system which is imperfectly understood cross-culturally. The physician, therefore, should acquaint themselves, minimally, with the norms of language use and

references to time within the patient's cultures. Likewise, they should examine the impact of prejudice on the lexicon of medical practice.

### Context of Therapy

Required readings: Glik (1988) and Koss (1987)

The Western model of psychotherapy has focused its attention on the individual rather than the social setting in which the patient experiences psychopathological symptoms. The individual is often treated as an isolate. This represents a change from age-old patterns of healing social discordance. Have students read these articles and discuss the rationale illustrated by Glik for the therapeutic effect of spiritual healing in these groups. Koss focuses on spiritist healing in Puerto Rico and finds that patients' expectations for relief of their symptoms are often high, and are met, in the context of group spiritual healing sessions. Koss correlates this success in some part to the selectivity of the spiritual healer's focus on certain individuals during the session and to the differences in the patient's perception of the personal characteristics of the therapist and the spiritist.

Students might be encouraged to discuss some of the patients they see during their clinical to examine whether there are ways in which a patient's family could be included in the treatment modality.

Or, alternatively, students might be asked to devise some symbolic rituals which could be used to operationalize or reinforce a patient's progress. For example, where disengagement from a personal relationship is desired by the patient (or indicated from a psychotherapeutic position), a ritual requiring the piece-by-piece disposal of a photograph of the other person could reinforce the progress the patient is making.

**The instructor may wish to refer to the Appendix for suggested questions and interview techniques which could form the basis for eliciting patients' culture-bound beliefs and behaviors regarding health issues.**

## REFERENCES FOR CITED READINGS

- Beiser, Morton, R. J. Turner and Soma Ganesan  
1989 Catastrophic Stress and Factors Affecting Its  
Consequences among Southeast Asian Refugees. Am.  
J. Psychiatry 145(1):46-51.
- Egeland, Janice A., Abram M. Hostetter and S. Kendrick  
Eshleman, III  
1983 Amish Study, III: the Impact of Cultural Factors  
on Diagnosis of Bipolar Illness. Am. J.  
Psychiatry 140(1):67-71.
- Fabrega, Horacio, Jr., M.D.  
1987 Psychiatric Diagnosis. A Cultural Perspective.  
J. Nerv. Ment. Dis. 175(7):383-94.
- Gilman, Sander L.  
1984 Jews and Mental Illness. Medical Metaphors,  
Anti-Semitism, and the Jewish Response. J. Hist.  
Beh. Sci. 20(2):150-159.
- Glik, Deborah C.  
1988 Symbolic, Ritual and Social Dynamics of Spiritual  
Healing. Soc. Sci. Med. 27(11):1197-1206.
- Koss, Joan D.  
1987 Expectations and Outcomes for Patients Given  
Mental Health Care or Spiritist Healing in Puerto  
Rico. Am. J. Psychiatry 144(1):56-61.
- Leininger, Madeleine  
1973 Witchcraft Practices and Psychocultural Therapy  
with Urban U.S. Families. Hum. Org. 32(1):73-83.
- Lopez, Steven and Priscilla Hernandez  
1986 How Culture is Considered in Evaluations of  
Psycho-pathology. J. Nerv. Ment. Dis.  
174(10):598-606.
- Pollock, Kristian  
1988 On the Nature of Social Stress: Production of a  
Modern Mythology. Soc. Sci. Med. 26(3):381-392.

## CULTURAL ISSUES IN FAMILY PRACTICE

### ILLUSTRATIVE CASE

Characterizing rheumatoid arthritis as being caused by the death of a parent or as due to a perceived injustice experienced by a patient may appear non-rational to the physician. So, too, might patients' characterizations of glaucoma as a "trickster" or "companion". Patient's beliefs and behaviors regarding what causes disease can block communication and frustrate the physician who does not comprehend how such beliefs can, when understood, become a basis for treating such patients. For example, an 80-year old male patient, a writer, characterizes glaucoma as both a companion of the aging process and a classic "trickster" which can provide both a new way of seeing and be a wily enemy to be managed. He complies with the medication regimen because he perceives the disease to have some positive effects in providing him with a different perspective on life. Also, he perceives his compliance as controlling the "trickster". However, where a patient perceives glaucoma a force which isolates, as something which has power over him and limits his world, non-compliance with a treatment program can be the rule. For example, a 68-year old Ph.D. retired college administrator and teacher characterizes glaucoma as part of an aging

process that is not part of his human nature, but rather something trust upon him from the outside. Having been a leader most of his professional life, he resists the assumption of his impending role as a dependent person. This patient equates growing old, and blind, as becoming inferior, becoming the powerless fool.

#### KEY ISSUES

Chronic illness presents a challenge for the family practitioner particularly in terms of compliance with prescribed medication regimens. This module helps the family practitioner recognize some of the cultural issues which can determine a chronically ill patient's compliance with treatment programs. Among such issues are:

**CONTRASTING VIEWS OF THE PHYSICIAN-  
PATIENT RELATIONSHIP**

**PATIENT-FAMILY RELATIONSHIP**

**PATIENT'S VIEW OF HIS/HER CHRONIC  
ILLNESS**

**TRADITIONAL MEDICAL TREATMENTS USED  
BY THE PATIENT**

Understanding how these cultural issues affect compliance will increase the physician's ability to begin negotiation for treatment and compliance during the initial history-taking interview.



## SUGGESTIONS FOR READING AND DISCUSSION

Contrasting Views of the Physician-Patient Relationship

Required readings: Trostle (1988) and Stimson (1974)

Have students read and discuss Trostle's analysis of compliance as an ideology which infers and supports the authority of the physician over the patient. Students should then contrast Stimson's report of the rationale for patients' non-compliance with Trostle's discussion of the physician's assumptions. Stimson relates non-compliance to the social context in which the patient experiences the illness and the treatment programs.

The instructor might have students also consider whether the growing awareness of personal responsibility for health is likely to increase non-compliance.

Patient-Family Relationship

Required readings: Markson (1971) and Young (1983)

A patient may persist in reporting symptoms indicative of non-compliance but which may actually represent the continuation of a meaningful sick role. Students should read and discuss the articles by Markson and Young to gain an appreciation for the sick role strategies which may be adopted to maintain family stability. The family's use of such strategies which may be maladaptive for the individual patient can be modified by negotiation between the patient, physician, and family members.

As an exercise, the instructor might require students to plan a treatment strategy to ameliorate the effects of the sick role on the patient.

### Patient's View of His/Her Chronic Illness

Required readings: Kugelmann and Bensinger (1983)

Patients' descriptions of their illness and its meaning for them may differ from the physician's view. After students have read this assigned article, they should be able to translate a patient's own metaphors about their chronic illness into negotiations for compliance.

Students might be encouraged to keep a journal of patients' descriptions of illness during their family practice clinical work. Students' sharing this information can increase their appreciation of the variety of ways in which they can affect compliance by working within the patient's cognitive framework.

### Traditional Medical Treatments Used by the Patient

Required readings: Klein (1978) and Bolton (1981)

Cross-cultural diagnosis and treatment of biomedically recognizable symptoms are especially difficult when the patient's health beliefs are at variance with biomedical models. Susto, a folk illness, represents one such case for physicians with Hispanic clientele. Students should read Klein and then Bolton and discuss the (1) biological, (2)

psychological, (3) social, and (4) cultural aspects of susto and susto-like syndromes.

The instructor may wish to have students attempt to identify these syndromes in biomedical terms and then design a treatment program which would include the patient's traditional medical treatments. Such a combination can enhance compliance.

**The instructor may wish to refer to the Appendix for suggested questions and interview techniques which could form the basis for eliciting patients' culture-bound beliefs and behaviors regarding health issues.**

REFERENCES FOR CITED READINGS

- Bolton, Ralph  
1981 Susto, Hostility, and Hypoglycemia. *Ethnology*  
20(4):261-276.
- Klein, Janice  
1978 Susto: The Anthropological Study of Diseases of  
Adaptation. *Soc. Sci. Med.* 12:23-28.
- Kugelmann, Robert and Richard Bensinger  
1983 Metaphors of Glaucoma. *Cult. Med. Psychiatry*  
7(3):313-328.
- Markson, E. W.  
1971 Patient Semeiology of a Chronic Disease. *Soc.*  
*Sci. Med.* 5:159-167.
- Stimson, Gerry V.  
1974 Obeying Doctor's Orders: A View from the Other  
Side. *Soc. Sci. Med.* 8:97-104.
- Trostle, James A.  
1988 Medical Compliance as an Ideology. *Soc. Sci.*  
*Med.* 27(12):1299-1308.
- Young, Rosalie F.  
1983 The Family-Illness Intermesh: Theoretical  
Aspects and Their Application. *Soc. Sci. Med.*  
17(7):395-98.

## CONCLUSIONS

This manual can provide a baseline integrative approach for increasing medical students' awareness of the impact which culture has upon health care. Upon its adoption and use in whole or in part, its effectiveness can be measured by a survey of students' attitudes and their ability to plan and negotiate treatment programs based upon cultural insights.

The nature, size, and content of the modules included in this present manual have been reviewed by a medical educator and by a community-based practicing physician (see footnote 1). In their opinion, the approach taken in this manual is both useful for the future physician and appropriate for use by the instructor. Further applications of the approach taken in this manual can be made to other specialized biomedical training programs, such as nursing, dentistry, and public health.

Exercises for students suggested throughout this manual focus on developing culturally-sensitive communication skills. The standard patient history-taking interview forms and case notes kept by the physician currently overlook the importance of cultural beliefs and behaviors in medical practice. An evaluation and revision of the patient history-taking interview form is recommended.

Such revisions should include questions to elicit cultural beliefs and behaviors and would reinforce the physician's understanding of the importance of cultural factors in patient care.

## SOURCES CONSULTED

- Angel, Ronald and Peggy Thoits. 1987. The Impact of Culture on the Cognitive Structure of Illness. *Cult. Med. Psychiatry* 11:465-494.
- Association of American Medical Colleges Project Panel on the General Professional Education of the Physician and College Preparation for Medicine. 1984. Physicians for the Twenty-First Century. *J. Med. Educ.* 59(11) Part 2.
- Barrows, Howard S., M.D. 1985. How to Design a Problem-Based Curriculum for the Preclinical Years. Springer Publishing Company, NY.
- Basker, Eileen. 1983. Coping with Fertility in Israel: A Case Study of Culture Clash. *Cult. Med. Psychiatry* 7(2):199-212.
- Beiser, Morton, R. J. Turner and Soma Ganesan. 1989. Catastrophic Stress and Factors Affecting Its Consequences among Southeast Asian Refugees. *Am. J. Psychiatry* 145(1):46-51.
- Berlin, Elois Ann, Ph.D. and William C. Fowkes, Jr., M.D. 1983. A Teaching Framework for Cross-Cultural Health Care. *West. J. Med.* 3(9):934-938.
- Bickel, Janet. 1987. Human Values Teaching Programs in the Clinical Education of Medical Students. *J. Med. Educ.* 62(5):369-378.
- Bolton, Ralph. 1981. Susto, Hostility, and Hypoglycemia. *Ethnology* 20(4):261-276.
- Bourhis, Richard Y., Sharon Roth, and Glenda MacQueen. 1989. Communication in the Hospital Setting: A Survey of Medical and Everyday Language Use Amongst Patients, Nurses and Doctors. *Soc. Sci. Med.* 28(4):339-346.
- Cayleff, Susan E. 1988. 'Prisoners of Their Own Feebleness': Women, Nerves and Western Medicine - A Historical Overview. *Soc. Sci. Med.* 26(12):1199-1208.
- Chambers, Erve. 1985. Applied Anthropology. Prentice-Hall, Inc., Englewood Cliffs, NJ.

- Chino, Harriet and Lothar Georg Vollweiler. 1986. Etiological Beliefs of Middle-Income Anglo-Americans Seeking Clinical Help. *Hum. Org.* 45(3):245-254.
- Clark, Margaret, Ph.D. 1983. Cultural Context of Medical Practice. *West. J. Med.* 3(9):806-810.
- Egeland, Janice A., Abram M. Hostetter and S. Kendrick Eshleman, III. 1983. Amish Study, III: the Impact of Cultural Factors on Diagnosis of Bipolar Illness. *Am. J. Psychiatry* 140(1):67-71.
- Eisenberg, Leon. 1977. Disease and Illness. Distinctions between Professional and Popular Ideas of Sickness. *Cult. Med. Psychiatry* 1:9-23.
- Fabrega, Horacio, Jr., M.D. 1987. Psychiatric Diagnosis. A Cultural Perspective. *J. Nerv. Ment. Dis.* 175(7):383-94.
- Feldman, Kenneth W. 1984. Pseudoabusive Burns in Asian Refugees. *Am. J. Dis. Child.* 138(8):768-9.
- Feldman, W., E. Feldman and J. T. Goodman. 1988. Culture versus Biology: Children's Attitudes toward Thinness and Fatness. *Pediatrics* 81(2):190-194.
- Fishman, Claudia, Robin Evans and Eloise Jenks. 1988. Warm Bodies, Cool Milk: Conflicts in Post Partum Food Choice for Indochinese Women in California. *Soc. Sci. Med.* 26(11):1125-1132.
- Freimer, Nelson, Dean Echenberg and Norman Kretchmer. 1983. Cultural Variation - Nutritional and Clinical Implications. *West. J. Med.* 139(6):928-933.
- Geertz, Clifford. 1984. Distinguished Lecture: Anti Anti-Relativism. *Am. Anth.* 86:263-78.
- Gilman, Sander L. 1984. Jews and Mental Illness. Medical Metaphors, Anti-Semitism, and the Jewish Response. *J. Hist. Beh. Sci.* 20(2):150-159.
- Glik, Deborah C. 1988. Symbolic, Ritual and Social Dynamics of Spiritual Healing. *Soc. Sci. Med.* 27(11):1197-1206.
- Goodenough, Ward H. 1978. Multiculturalism as the Normal Human Experience. IN *Applied Anthropology in America*. Eddy, Elizabeth M. and William L. Partridge, eds. Columbia University Press, NY.



- Hahn, Robert A. 1982. Treat the Patient, Not the Lab: Internal Medicine and the Concept of "Person". *Cult. Med. Psychiatry* 6(3):219-236.
- Harkness, Sara. 1987. The Cultural Mediation of Postpartum Depression. *Med. Anth. Qtrly.* 1(2):194-209.
- Hartog, Joseph, M.D. and Elizabeth Ann Hartog, R.N., M.A. 1983. Cultural Aspects of Health and Illness Behavior in Hospitals. *West. J. Med.* 139(6):910-916.
- Harwood, Alan (ed.). 1981. *Ethnicity and Medical Care.* Harvard University Press, Cambridge, MA.
- Herskovits, Melville J. 1972. *Cultural Relativism: Perspectives in Cultural Pluralism.* Random House, NY.
- Johnson, Thomas M. 1987. Premenstrual Syndrome as a Western Culture-Specific Disorder. *Cult. Med. Psychiatry* 11:337-356.
- Katon, Wayne and Arthur Kleinman. 1980. Doctor-Patient Negotiation and Other Social Science Strategies in Patient Care. IN *The Relevance of Social Science for Medicine.* Eisenberg, L. and A. Kleinman (eds.). D. Reidel Publishing Company, Holland.
- Katz, Pearl and Faris R. Kirkland. 1988. Traditional Thought and Modern Western Surgery. *Soc. Sci. Med.* 26(12):1175-1181.
- Keessing, Roger M. 1974. Theories of Culture. *Ann. Rev. Anth.* 3:73-97.
- Klein, Janice. 1978. Susto: The Anthropological Study of Diseases of Adaptation. *Soc. Sci. Med.* 12:23-28.
- Kleinman, Arthur M. 1974. Cognitive Structures of Traditional Medical Systems: Ordering, Explaining, and Interpreting the Human Experience of Illness. *Ethnomedizin* III:27-49.
- Kleinman, Arthur, M.D., M. A., Leon Eisenberg, M.D., and Byron Good. 1978. Culture, Illness, and Care. *Ann. Intern. Med.* 88:251-258.
- Koo, Linda C. 1984. The Use of Food to Treat and Prevent Disease in Chinese Culture. *Soc. Sci. Med.* 18(9):757-766.

- Koss, Joan D. 1987. Expectations and Outcomes for Patients Given Mental Health Care or Spiritist Healing in Puerto Rico. *Am. J. Psychiatry* 144(1):56-61.
- Kugelman, Robert and Richard Bensinger. 1983. Metaphors of Glaucoma. *Cult. Med. Psychiatry* 7(3):313-328.
- Leininger, Madeleine. 1973. Witchcraft Practices and Psychocultural Therapy with Urban U.S. Families. *Hum. Org.* 32(1):73-83.
- Lin, Elizabeth H. 1983. Intraethnic Characteristics and the Patient-Physician Interaction: "Cultural Blind Spot Syndrome". *J. Fam. Pract.* 16(1):91-8.
- Lipton James A. and Joseph J. Marbach. 1984. Ethnicity and the Pain Experience. *Soc. Sci. Med.* 19(12):1278-1298.
- Lock, Margaret. 1982. Models and Practice in Medicine: Menopause as Syndrome or Life Transition? *Cult. Med. Psychiatry* 6:261-280.
- Lopez, Steven and Priscilla Hernandez. 1986. How Culture is Considered in Evaluations of Psycho-pathology. *J. Nerv. Ment. Dis.* 174(10):598-606.
- Lynch, L. Riddick, ed. 1969. *The Cross-Cultural Approach to Health Behavior*. Associated University Presses, Inc., Cranbury, NJ.
- Mao, Constance, M.D., Carletta Sara Bullock, M.D., Elana Carla Harway, M.D., and Sadhna Kaur Khalsa, M.D. 1988. A Workshop on Ethnic and Cultural Awareness for Second-Year Students. *J. Med. Educ.* 63(8):624-628.
- Markson, E. W. 1971. Patient Semeiology of a Chronic Disease. *Soc. Sci. Med.* 5:159-167.
- McGuire, Christine H., Richard P. Foley, Alan Gorr, Ronald W. Richards, and Associates. 1983. *Handbook of Health Professions Education*. Jossey-Bass Publishers, San Francisco.
- Moore, Lorna G., Ph.D., Peter W. Van Arsdale, Ph.D., JoAnn E. Glittenberg, R.N., Ph.D., Robert A. Aldrich, M.D. 1980. *The Biocultural Basis of Health*. The C.V. Mosby Company, St. Louis.
- Nurge, Ethel. 1975. Anthropological Perspective for Medical Students. *Hum. Org.* 34:345-352.

- Pelto, Pertti J. and Gretel H. Pelto. 1975. Intra-Cultural Diversity: Some Theoretical Issues. *Am. Ethnologist* 2(1):1-18.
- Pfifferling, John-Henry. 1981. A Cultural Prescription for Medicocentrism. IN *The Relevance of Social Science for Medicine*. Eisenberg, L., and A. Kleinman (eds.). D. Reidel Publishing Company, Holland.
- Pillsbury, Barbara L. K. 1978. "Doing the Month": Confinement and Convalescence of Chinese Women after Childbirth. *Soc. Sci. Med.* 12:11-22.
- Pollock, Kristian. 1988. On the Nature of Social Stress: Production of a Modern Mythology. *Soc. Sci. Med.* 26(3):381-392.
- Read, Margaret. 1966. *Culture, Health, and Disease*. Tavistock Publications, London.
- Renteln, Alison Dundes. 1988. Relativism and the Search for Human Rights. *Am. Anth.* 90(1):56-72.
- Redlener, Irwin E. and Clarissa S. Scott. 1979. Incompatibilities of Professional and Religious Ideology: Problems of Medical Management and Outcome in a Case of Pediatric Meningitis. *Soc. Sci. Med.* 13B:89-93.
- Rohner, Ronald P. 1984. Toward a Conception of Culture for Cross-Cultural Psychology. *J. Cross-Cult. Psychology* 15(2):111-138.
- Scott, Clarissa. 1975. The Relationship between Beliefs about the Menstrual Cycle and Choices of Fertility Regulating Methods within Five Ethnic Groups. *Intl. J. of Gyn. Obs.* 13:105-109.
- Snyder, Patricia. 1981. Ethnicity and Folk Healing in Honolulu, Hawaii. *Soc. Sci. Med.* 15B:125-132.
- Spinetta, John J. 1984. Measurement of Family Function, Communication, and Cultural Effects. *Cancer* 53(5):2330-2338.
- Stern, Gwen and Laurence Kruckman. 1983. Multi-Disciplinary Perspectives on Post-Partum Depression: An Anthropological Critique. *Soc. Sci. Med.* 17(15):1027-1041.
- Stimson, Gerry V. 1974. Obeying Doctor's Orders: A View from the Other Side. *Soc. Sci. Med.* 8:97-104.

- Sundance, Paula, M.D., Igor Grant, M.D. and Kenneth Moser, M.D. 1985. Integration of the Social and Behavioral Sciences into the Core Medicine Clerkship. *J. Med. Educ.* 60(11):881-883.
- Swartz, Leslie. 1985. Anorexia Nervosa as a Culture-Bound Syndrome. *Soc. Sci. Med.* 20(7):725-730.
- Thomas, James D. 1985. Gypsies and American Medical Care. *Ann. Intern. Med.* 102(6):842-5.
- Trostle, James A. 1988. Medical Compliance as an Ideology. *Soc. Sci. Med.* 27(12):1299-1308.
- Troyer, Henry. 1988. Review of Cancer among 4 Religious Sects: Evidence that Life-Styles are Distinctive Sets of Risk Factors. *Soc. Sci. Med.* 26(19):1007-1017.
- Tryoler, H. A. and John Cassel. 1964. Health Consequences of Culture Change - II. The Effect of Urbanization of Coronary Heart Mortality in Rural Residents. *J. Chron. Dis.* 17:167-177.
- Wells, Kenneth B., M.D., M. Christina Benson, M.D. and Pamela Hoff. 1985. Teaching Cultural Aspects of Medicine. *J. Med. Educ.* 60(6):493-495.
- Wetzel, Randall C., J. Michael Dean and Mark C. Rogers. 1983. Gypsies and Acute Medical Intervention. *Pediatrics* 72(5):731-5.
- Whorton, James C. 1987. Traditions of Folk Medicine in America. *JAMA* 87:1632-36 (3/27/87).
- Young, Allan. 1982. The Anthropologies of Illness and Sickness. *Ann. Rev. Anth.* 11:257-85.
- Young, Rosalie F. 1983. The Family-Illness Intermesh: Theoretical Aspects and Their Application. *Soc. Sci. Med.* 17(7):395-98.
- Zeskind, Philip Sanford. 1983. Cross-Cultural Differences in Maternal Perceptions of Cries of Low- and High-Risk Infants. *Child Dev.* 54(5):1119-1128.
- Zola, Irvin Kenneth. 1966. Culture and Symptoms - An Analysis of Patients' Presenting Complaints. *Am. Soc. Rev.* 31:615-630.

## APPENDIX

In developing medical students' cross-cultural sensitivity and communication skills, the instructor may wish to refer to certain critical questions suggested by various authors (e.g., Kleinman, et al. [1978]; Harwood [1981]; and, Pfifferling [1981]). These questions are structured to probe the cultural dimensions implicit in health:disease:illness issues regardless of the cultural orientation of the physician or the patient. Posing these types of questions in a non-judgmental, sincere manner in an interview with a patient may well prove difficult for the new physician. Repeated encouragement toward developing this skill is essential and is one of the primary goals of the exercises suggested throughout this manual.

These questions can also provide the basis upon which the patient interview or medical history-taking forms might be evaluated and revised. Recognizing that each medical specialty may have a form considered most appropriate, no attempt is made to suggest specialty-specific questions. Likewise, recognizing the importance of inter- and intraethnic differences among patients, no attempt is made to suggest any culture-specific questions. However, the physician may find that any number of the following

questions may be useful in specific situations, regardless of the cultural identity of the patient.

Kleinman, et al. (1978:256-7) suggest that the following eight questions be asked of patients and the answers recorded as illness problems and evaluated in designing treatment programs for disease problems.

- [1] What do you think has caused your problem?
- [2] Why do you think it started when it did?
- [3] What do you think your sickness does to you?  
How does it work?
- [4] How severe is your sickness? Will it have a short or long course?
- [5] What kind of treatment do you think you should receive?
- [6] What are the most important results you hope to receive from this treatment?
- [7] What are the chief problems your sickness has caused for you?
- [8] What do you fear most about your sickness?

Harwood (1981:29) argues that the above questions may pose problems for patients from various ethnic groups whose expectations of the physician's role are not being met when a physician asks such questions. He specifically rewords [4] and [5] above with the caveat that even as restated they may pose misunderstanding. He suggests:

- [4] How bad (severe) do you think your illness is?  
Do you think it will last a long time, or will it be better soon in your opinion?
- [5] What kind of treatment would you like to have?

Pfifferling (1981:207) has devised a set of questions particularly useful for eliciting the patient's expectations of the physician and the social context in which the patient's illness is being experienced and in which they

are/may be seeking other curative/healing assistance. His "Cultural Status Exam" follows.

- I. How would you describe the problem that has brought you to me?
  - (a) Is there anyone else with you that I can talk to about your problem?  
(If yes, to significant other: Can you describe X's problem?)
  - (b) Has anyone else in your family/friend network helped you with this problem?
- II. How long have you had this (these) problem(s)?
  - (a) Does anyone else have this problem that you know? If yes, describe them, how old they are, and their different manifestations.
- III. What do you think is wrong, out of balance, or causing your problem?
  - (a) Who else do you know who has, or gets this kind of problem?
  - (b) Who, or what kind of people don't get this problem?
- IV. Why has this problem happened to you, and why now?
  - (a) Why has it happened to (the involved part)?
  - (b) Why did you get sick and not someone else?
- V. What do you think will help to clear up your problem?
  - (a) If they suggest specific tests, procedures, or drugs, ask them to further define what they are and how they will help.
- VI. Apart from me, who else do you think can help get you better?
  - (a) Are there things that make you feel better, or give you relief, that doctors don't know about?

Using open-ended questions such as these will lead to further avenues of information sharing and can provide the clues necessary to negotiate compliance with biomedically indicated treatment. Katon and Kleinman (1981:270-1) discuss the steps in the negotiating process once these kinds of questions have been presented and answered. Their

approach has been organized into a mnemonic by Berlin and Fowkes (1983:934) known as **LEARN**. The components consist of (emphasis in the original):

- L Listen** with sympathy and understanding to the patient's perception of the problem
- E Explain** your perceptions of the problem
- A Acknowledge** and discuss the differences and similarities
- R Recommend** treatment
- N Negotiate** agreement

Katon and Kleinman do consider ongoing monitoring an important additional component which often requires continued negotiation between physician and patient and their social network.