# Cultural Context of Medical Practice

SPECIAL GUEST EDITOR
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One of the most striking characteristics of the contemporary American West is the number and variety of ethnic minority group members who make it their home. There has been a steady growth of migrant and immigrant populations in the western states for more than a century. While the overall US population is rapidly expanding, growing by 6% between 1970 and 1980, the West has increased at an even more rapid rate. Rates of growth for individual states range from a low of 13.3% in Montana to a high of 63.5% in Nevada.[1] During the 1970s, furthermore, the number of minority group members increased at a much more rapid rate than did the US population generally. Blacks grew by 17.3%, Native Americans and Hispanics* by even more, and the number of Asian and Pacific Island peoples more than doubled in the ten-year period.[2] With the exception of blacks, all major ethnic groups are heavily overrepresented in the West (See Table 1). For example, in 1980 42.8% of all Hispanics, 50.7% of Native Americans, 52.7% of Chinese-Americans, 69.3% of Pilipino-Americans† and 80.6% of Japanese-Americans lived in the western states.

Many western US cities contain many tens of thousands of immigrants from every major part of the world. For example, it is estimated that since 1970, 2 million foreign immigrants have settled in the Los Angeles area alone, more than 90,000 of them during the single year of 1982. According to one report, "of L.A.'s 550,000 schoolchildren, 117,000 speak one of 104 languages better than they do English" (*Time*, June 13, 1983, p 20).

With such numbers and such proportions, it is impossible for physicians and other health professionals to ignore the special problems and needs of patients from these communities. These problems are of several kinds: First, many immigrant and refugee populations have higher rates of infectious disease and parasitic infestation than the general population. Furthermore, stress-related disorders are more common in migrant groups who often suffer social, economic and cultural dislocations, as well as discrimination and poverty. Traditionally high birth rates among immigrant families also bring many women and infants into contact with medical institutions. In sum, increasing numbers of minority group patients are likely to find their way into the practices of most physicians in this country, whether in offices, hospitals or clinics. Cultural diversity shows no signs of abating, and medical practitioners are increasingly aware of the problems inherent in transcultural medical practice.

*Census data indicate that the population of Spanish-speaking origin increased by 61.0% and Native Americans by 71.4% between 1970 and 1980; however, these figures are likely inflated because of changes in census procedures.

†*Pilipino* has recently come to be preferred over Filipino by immigrants to the United States for purposes of ethnic identity, in line with the usage adopted by the national language of the Philippines (which does not have the letter "f").

## The Nature of Cultural Barriers in Health Care

The papers in this special collection are devoted to an examination of the kinds of problems that arise as a result of disparities between the cultural backgrounds of patients and practitioners. Most of the papers assume that physicians will be middle-class Americans and that their task will be to understand and deal with patients who are not of that background. Of course this is not always the case; by no means are all health practitioners middle-class English speakers. Yet the principles of medical anthropology are just as relevant for minority group practitioners or foreign medical graduates as for anyone else. All major cultural groups contain class or ethnic subgroups whose ideas about illness and proper professional behavior may differ widely. In a pluralistic society such as ours, everyone must find ways to communicate with others whose worlds of symbols and meaning are so different from their own.

In any discussion of ethnic variability and health care, it is important to remember that there are great individual differences within all ethnic communities in health knowledge, attitudes and behavior. Some research has indicated that there may be more discrepancies among persons of different educational and class levels *within* an ethnic category than exist *across* ethnic boundaries, if the individual persons have similar educational and social class backgrounds and are equally familiar with mainstream American life. In general, people of lower socioeconomic status tend to behave "more ethnically" in health matters than do those of

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TABLE 1.—*Resident Population in Western States by Race and Spanish-Speaking Origin*

| Race or Origin | Total US N in Thousands | Western States* N in Thousands | Western States* Percent of Group |
|---|---|---|---|
| Total | 226,546.0 | 43,173.0 | 19.0 |
| White | 188,372.0 | 34,890.0 | 18.5 |
| Black | 26,295.0 | 2,262.0 | 8.5 |
| American Indian† | 1,420.4 | 720.8 | 50.7 |
| Chinese | 806.0 | 424.8 | 52.7 |
| Pilipino | 774.7 | 537.0 | 69.3 |
| Japanese | 701.0 | 565.0 | 80.6 |
| Asian Indian | 361.5 | 72.0 | 19.9 |
| Korean | 354.6 | 153.9 | 43.4 |
| Vietnamese | 261.7 | 119.9 | 45.8 |
| All other races | 6,999.2 | 3,427.4 | 49.0 |
| Spanish-speaking origin‡ | 14,609.0 | 6,254.0 | 42.8 |

[Derived from data presented in US Bureau of the Census. Current Population Reports.[2(p32)]]

* Includes Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada, Washington, Oregon, California, Alaska and Hawaii.

† Includes Eskimo and Aleut.

‡ Persons of Spanish-speaking origin may be of any race.

higher socioeconomic levels. Also, "the more homogeneous and close-knit social relationships are for individuals within any ethnic group, the less biomedically oriented their health attitudes are likely to be."[3(p12)] This is as true of native English-speaking patients as it is of any other group.

Let me turn now to a brief general discussion of some of the cultural barriers to clinical care that are discussed in the following papers. They deal in the main with five categories: (1) language use and nonverbal communication patterns, (2) medical roles and responsibilities, (3) explanatory models of disease, (4) contextual factors, and (5) emotional impact and stigma. The various papers *in toto* deal with all these topics, although no single article treats all of them. At the end of this article, a set of readings is provided that treats them in fuller detail.

### *Language Barriers and Communication Patterns*

Without language, the work of a physician and that of a veterinarian would be nearly identical. In cases where there is little or no common understanding between patient and practitioner, the necessary use of interpreters is sometimes satisfactory, but in other instances is fraught with difficulties. Lay interpreters may know little medical terminology, and may require careful explanations about the kind of information that is required from the patient. In some instances, interpreters may come from a different educational or social stratum from that of the patient, and social distance and rules of decorum may render communication difficult. In my personal experience, a well-educated or highly acculturated member of an ethnic category is often reluctant to report patients' statements accurately if those statements seem to reflect what the interpreter regards as "ignorance" or "superstition." Much useful medical information can thus be lost. In some cases bilingual adolescent or adult children can be used as interpreters, unless the material to be translated contains information that is a taboo subject for discussion between parent and child (much gynecological information is of this nature). For these various reasons, the language barrier may prove a difficult one. Even so, in cases where an accurate history is essential, it will pay the clinician to take some care in obtaining proper translation.

Nonverbal communication patterns also vary from culture to culture. Hand-shaking and smiling are essential ingredients of productive medical interactions with Latino and working-class black patients, but have been found to signify frivolity and immaturity to Soviet emigrés (see the papers by Snow, by Maduro and by Wheat, Brownstein and Kvitash in this issue). Some attention to traditional patterns of demeanor and decorum will prove a useful addendum to the knowledge of the clinician in interethnic encounters.

### *Medical Roles and Responsibilities*

Much has been written about the expectations that patients from a variety of ethnic backgrounds have of health personnel. In general, members of most ethnic minority groups in this country are unwilling to relinquish to medical personnel complete control over the care of a patient, even in acute care settings. In reports of the behavior of Arab families, for example, patients' beds are described as

> invariably surrounded by relatives and friends. The health care providers are amazed at the number of persons who are constantly in the way of the hospital routine and who seem to interfere with the kind of care the health care personnel prefer to give.[4(p892)]

As several articles in this issue explain (Lipson and Meleis, Kim, Hartog and Hartog, for example) family members and close associates are expected to be near the patient as much as possible, to provide emotional support, to take care of special needs that hospital personnel do not provide (special foods, herbal medicines, massage and the like), and to monitor the medical treatment. These articles demonstrate the kinds of conflicts that often arise when familial roles are neither understood nor accepted by medical personnel.

In some cases, alternative healers are sought to provide supplementary kinds of treatment simultaneously with that of biomedical specialists. Reasons for this behavior are related to ideas about different levels of causality, as discussed below. Family members often arrange through a "lay referral system" for alternative forms of care, as part of their culturally defined obligation to see that their ailing relative has access to a full range of possible cures. In many ethnic communities responsibility for the patient's healing is not "turned over" to the physician but remains with patient and family. As Lock points out in her article on Japanese attitudes: "the physician is a skilled and sympathetic technician," whose role is to assist in the cure, not to take it over. In sum, culturally patterned medical roles influence doctor-patient and other medical relation-

ships by establishing guidelines for what is considered appropriate clinical responsibility and communication.

*Explanatory Models of Disease*

Explanatory models in all cultures go far beyond ideas about specific pathogens, dislocations, toxins, traumata, degenerations or biochemical imbalances. They are broadly gauged systems of concepts about the nature of illness and its place in human existence. For example, they explain what disease is, how it comes about, why it exists, what can prevent it or control it or cure it, and why it attacks some people but not others. Human beings seem to have a need to provide explanations for themselves of various kinds of good and ill that befall them. In even the simplest human societies, explanations are advanced and weighed about the reasons for floods, hurricanes, earthquakes, stillbirths, malformations, failed crops, drownings, disease and death. Explanatory models serve to allay anxious fears that accompany otherwise inexplicable events. People are eager to believe themselves in control of natural and supernatural forces rather than the passive victims of some blind and random cosmic process; much of human theory, including science and religion, developed in response to this need. Explanatory models of disease are a part of this body of theory.

Explanatory models have many functions; first, they provide criteria for judging whether or not an individual is really sick. Some cultures find it difficult to accept certain "manifestations" of disease that they cannot comprehend. For some, on the one hand, laboratory results may have little meaning in the absence of pain, fever, malaise or other symptoms. On the other hand, Anglo-Americans do not ordinarily regard recurrent dreams about the dead as a symptom of pathology, as the Navajos do.

A second function of such models is to deal with multiple levels of causality. In other words, a disease model not only provides an explanation for how an illness comes to exist; it also affords a reason why a particular patient happened to fall ill. If the explanatory model is sufficiently complex, it may even provide a list of possible contributory or intervening factors, and ways of warding off or increasing one's resistance to attacks. The three principal levels of causality that are addressed by explanatory models are (1) immediate causes (such as pathogens, malignancies, thrombi), (2) underlying causes (exposure to infection, smoking, atherosclerosis secondary to high blood cholesterol levels) and (3) ultimate causes (genetic susceptibility, bad luck, "stress," insufficient exercise, diet, the "tensions of modern life" and so on).

Cultures differ in the levels of explanation they provide. As one writer has said:

> the distinctive feature of modern science has been the extent of radical delimitation of causal paradigms to immediate causes. . . . Ultimate, purposive causes have been relegated to religion or philosophy as nonscientific issues. Medically, this means that when a patient asks *why* he is ill, he receives an answer about *how* he became ill. Since modern medicine has identified an impressive array of causal sequences, the scientist feels he has provided a satisfactory answer.[5(p432)]

By contrast, members of most non-Western societies deal with other aspects of cause. They want to know why in one child in the same family as another child—eating the same food, sleeping in the same room—leukemia developed, and did not in the sibling. It is in this area of ultimate causes that most of the so-called folk systems of medicine provide explanations, remedies, diagnostic aids and curative measures.

As I noted above, the fact that different medical systems are directed to different levels of cause explains the phenomenon of *medical pluralism*: the fact that a family may happily bring a sick member to a physician's office or clinic for treatment of the "immediate cause," and at the same time be consulting a healer who will search for and deal with the "ultimate cause." In some cultures, it is accepted that an able physician is the obvious choice to reduce a fracture and apply a cast; but only a medicine man can determine why the patient was so out of harmony with his environment that he fell and broke his leg.

Explanatory models deal with larger issues than cause and effect. They may answer questions such as these: Is health merely absence of disease or is it a separate dimension that varies in intensity even in the absence of symptoms? Will ritual purity protect a person from disease? Must one constantly work at staying well, or is health a normal state of homeostasis that will be interrupted only by external malevolent forces? What is the temporal locus of illness? Is an episode of disease something that started happening long ago, perhaps even before the patient was born? Will the asymptomatic present finally emerge as a tardy though inevitable condition? Clearly the answers provided to such questions in various cultures will affect what people do about sickness and health.

*Contextual Factors*

Many of the articles in this issue deal with various aspects of culturally patterned behavior that are not an integral part of the medical system, but that clearly play a large role in levels of health and the kinds of health problems most often found. For example, cultural patterns in diet, socialization of children, sexual behavior, exercise, the balance of work and rest, ritual observances and many other everyday activities have great import for health status. A substantial literature exists on each of these topics, but they can be dealt with only briefly here. Anderson, Freimer and coworkers, Muecke, Book and associates and others touch on some of these contextual issues.

*Emotional Impact and Stigma*

While all major disease has emotional consequences for both patient and family, some disease entities have greater impact than others. Cancer is universally feared and dreaded, even in its more treatable forms. In some groups (Native Americans, working-class blacks, Latinos) tuberculosis is a dread disease. Cultural attitudes differ in the face of possible disfigurement, prolonged pain or chronic disability.[6,7] One of the most common

attitudes reported for members of American ethnic minority groups is the degree of stigma attached to mental illness. This stigmatization is related to a tendency to interpret psychological or psychophysiological symptoms as manifestations of somatic disorder alone. Lin, Lock and Brodsky deal with this topic in some detail.

Among Hispanic groups (as reported by Maduro and by Scheper-Hughes and Stewart in this issue) prolonged emotional states are regarded as precursors as well as consequences of disease. In these as well as in other cultures, there is a greater appreciation of the inextricable interrelationships of psychic and somatic phenomena than is common in Anglo-American groups.

## The Plan of This Special Issue

In selecting a set of articles for this journal issue, I drew on two principal sources: medical anthropologists who have spent years in most cases studying the cultures and ethnomedical systems of societies that are represented in the United States, particularly in the West. Second, practicing physicians from a variety of specialties in which we have found cultural factors play a major role in eliciting history, establishing diagnosis, obtaining the help and cooperation of family and friends, and convincing patients to follow through with a recommended course of treatment. In some instances, papers have been prepared by teams of physicians, anthropologists and others. In two articles nurse-anthropologists have contributed their special insights.

The first ten articles discuss the ethnomedical backgrounds of nine different cultural groups, ranging from those living in North America long before English-speaking colonists arrived here (Native Americans of Alaska and Hispanic peoples of the Southwest) to the newest arrivals in the United States (the Southeast Asian "boat people" and other Indochinese refugees). In addition to these 9 groups, the final 9 articles deal with two additional ethnic groups, making a total of 11 different ethnic cultures. In order of presentation, these include the following: Pilipinos (Anderson), lower class black Americans (Snow), Japanese-Americans (Lock), Southeast Asian refugees (Muecke), Jamaicans (Mitchell), Pacific Islanders (Fitzpatrick-Nietschmann), Middle Easterners (Lipson and Meleis), Chinese-Americans (Lin), Latinos (Maduro; Scheper-Hughes and Stewart), Soviet Jewish emigrés (Wheat and co-workers) and Alaskan Natives (Dixon and associates; Book and co-workers).

One of the unfortunate omissions in this issue is a discussion of Native American ethnomedicine in the Southwest. Several hoped-for articles did not materialize in time for inclusion here. Readers are referred to excellent articles in the medical anthropological literature on Native Americans, particularly a discussion of Navajo health and medical practices by Kunitz and Levy.[8]

This issue contains clinical and case material from nine medical specialties. These papers, by physicians or anthropologist/physician co-authors are as follows: psychiatry (Lin), geriatrics (Kim), rehabilitation medicine (Brodsky), internal medicine (Wheat and co-workers), obstetrics and gynecology (Minkler), hospital practice (Hartog and Hartog), public health practice (Dixon and associates), nutrition (Freimer and co-workers) and family practice (Berlin and Fowkes).

## Sources of Information on Cultural Medicine

There is a growing body of literature in medical anthropology and in cross-cultural medicine to which I would like to refer interested readers. One publication closely related to the theme of this special issue is *Ethnicity and Medical Care,* a volume edited by Alan Harwood.[3] It contains chapters on four American ethnic minority groups that are not discussed in the present collection: Haitian-Americans, Italian-Americans, Navajos (which I have already mentioned), and Mainland Puerto Ricans. The other chapters are on groups represented here (urban black Americans, Chinese-Americans and Mexican-Americans), but those discussions provide different material from those in this issue. Among other collections and general works on ethnicity and medical care are Spector's *Cultural Diversity in Health and Illness*[9] and Spicer's edited volume *Ethnic Medicine in the Southwest.*[10]

Various collections of papers on medical anthropology are readily available. One of the more extensive is Landy's book *Culture, Disease and Healing: Studies in Medical Anthropology.*[11] Other useful collections are by Klein,[12] Leslie,[13] and Logan and Hunt.[14] The medical anthropology text by Foster and Anderson[15] contains helpful discussions and bibliography.

Several journals in the field of medical anthropology are valuable ongoing resources: *Social Science and Medicine, an International Journal* (Pergamon Press, Oxford)—particularly the medical anthropology series edited by Charles Leslie, *Medical Anthropology: Cross-Cultural Studies in Health and Illness* (Redgrave Publishing Company, South Salem, New York), *The Medical Anthropology Quarterly* (Society for Medical Anthropology, Washington, DC), and *Culture, Medicine and Psychiatry* (D. Reidel Publishing Company, Dordrecht, Netherlands). One journal published by the American Sociological Association (Washington, DC), *Journal of Health and Social Behavior,* frequently offers papers on cross-cultural health studies.

Two series of yearbooks devote one or more major review articles of each issue, as a rule, to medical anthropology or cross-cultural medicine. The first of these is the *Annual Review of Anthropology,* whose most recent issue contains reviews by Young[16] and Worsley.[17] The other, a new series, *Advances in Medical Social Science,* has published only a single 1983 volume; the relevant articles are those by Landy[18] and Hughes and Kennedy.[19]

Finally, the medical literature has long contained a sprinkling of papers on ethnicity, cultural variability and medical anthropology, and such reports are increasing in frequency. *The Western Journal of Medicine* for the past several years has been publishing reports

on cross-cultural medicine in a regular section. As Special Guest Editor of this issue, I want to commend Dr Malcolm S. M. Watts for his interest in this topic, and thank him for his encouragement and support.

## REFERENCES


1. 1980 Census of Population, Supplementary Report PC80-S1-1. US Government Printing Office, US Bureau of the Census, May 1981
2. Current Population Reports: Population Characteristics. Series P-20, No 374—Population Profile of the United States: 1981. US Bureau of the Census, Washington DC, 1982
3. Harwood A (Ed): Ethnicity and Medical Care. Cambridge, Harvard University Press, 1981
4. Meleis AI, Jonsen AR: Ethical crises and cultural differences (Medicine in Perspective). West J Med 1983 Jun; 138:889-893
5. Nydegger CN: Multiple causality: Consequences for medical practice (Cross-cultural Medicine). West J Med 1983 Mar; 138:430-436
6. Macgregor FC: Some psychological hazards of plastic surgery of the face. Plast Reconstr Surg 1953 Aug; 12:123-130
7. Zborowski M: People in Pain. San Francisco, Jossey-Bass, 1969
8. Kunitz SF, Levy JE: Navajos, *In* Harwood A (Ed): Ethnicity and Medical Care. Cambridge, Harvard University Press, 1981, pp. 337-396
9. Spector R: Cultural Diversity in Health and Illness. New York, Appleton-Century-Crofts, 1979
10. Spicer EH (Ed): Ethnic Medicine in the Southwest. Tucson, University of Arizona Press, 1977
11. Landy D (Ed): Culture, Disease, and Healing. New York, Macmillan, 1977
12. Klein N (Ed): Culture, Curers and Contagion: Readings for Medical Social Science. Novato, Calif, Chandler and Sharp, 1979
13. Leslie C (Ed): Asian Medical Systems: A Comparative Study. Berkeley, University of California Press, 1976
14. Logan MH, Hunt EE Jr, (Eds): Health and the Human Condition: Perspectives on Medical Anthropology. North Scituate, Mass, Duxbury Press, 1978
15. Foster GM, Anderson BG: Medical Anthropology. New York, Wiley, 1978
16. Young A: The Anthropologies of illness and sickness. Annu Rev Anthropol 1982; 11:257-285
17. Worsely P: Non-Western medical systems. Annu Rev Anthropol 1982; 11:315-348
18. Landy D: Medical anthropology: A critical appraisal, *In* Ruffini JL (Ed): Advances in Medical Social Science, vol 1: New York, Gordon and Breach, 1983, pp 185-314
19. Hughes CC, Kennedy DA: Beyond the germ theory: Reflections on relations between medicine and the behavioral sciences, *In* Ruffini JL (Ed): Advances in Medical Social Science, vol 1, New York, Gordon and Breach, 1983, pp 321-399