CULTURAL ATTITUDES IN MEDICAL PRACTICE IN THE WESTERN HEMISPHERE

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In today's world of advanced communications, technology and rapid transportation, adequate medical care is still not available to everyone in the Western Hemisphere. For clarity, the Western Hemisphere will be divided into First World (North America), Second World (urban centers of Central America, the Caribbean, and South America) and Third World (under-developed areas), or North America and Developing America.

It is generally accepted that the urban centers offer "better" facilities than do the rural areas, and likewise, the wealthy enjoy "better" medical care than do the poor.

This paper explores the attitudes of doctors and patients in the different regions towards each other and towards their respective systems. It examines the complexities in communication between doctors and patients, and among doctors themselves; economic differences with regards to technology; cultural variations with regards to diet, regional traditions, and religious attitudes , and their effects on the theory and practice of medicine; and inherent prejudices that are so obviously wrong and yet so difficult to overcome.

There is a distinct need for a higher awareness and implementation of corrective measures on the parts of both patients and doctors, of the hazards of rigid pre-formed attitudes in medical care when dealing with and in different cultures.

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Introduction...

"The Lord hath created medicines out of the earth: and he that is wise will not abhor them." Ecclesiastes 38:4

"I don't trust a doctor who can't speak English."
Hyman Roth, character in the movie, Godfather II

Only two percent of the world's plants have been analyzed; only a small portion of these are in use as medicines; North America largely ignores the use of phytotherapy and shows little interest in those who practice it and other natural therapies.

There is no place in the practice of medicine for negative biases based on cultural differences. The more advanced medical community must broaden its scope, familiarize itself with and respect the various cultures at least within its immediate sphere of contact. The less advanced medical community must be aware of the technology available and strive to attain the economic stability necessary to gain adequate access to it.

II. Definition...

Culture consists of the concepts, habits, skills, behavior, art, instruments and institutions of a given people in a given period of time. Attitude is the manner of acting, feeling or thinking that reflects ones disposition and opinion. Cultural differences and the attitudes that accompany them have long been a source of conflict for the inhabitants of the Western Hemisphere. For purposes of reference, the Western Hemisphere shall be divided into the technologically advanced North America (Canada and the United States) and the less technologically advanced Developing Americas (Mexico and Central America, the Caribbean and South America), noted as NA and DA respectively.

III. Facts...

There are certain areas in NA which are medically more deprived than certain areas in the DA.

Rich countries can afford better health care facilities than can poor ones and also attract and maintain a disproportionate share of available medical staff and technicians. Hospital beds are 6/1000 in NA and only 2.7/1000 in DA. The average number of doctors in NA is 2000 per one million vs. 630 per one million in DA.(1)

NA spends 12% of its GNP on health care yet it does not achieve the highest standard due to inadequate and inappropriate distribution of these funds. This is indirectly attributed to the inclusion of the health problems of minorities. Developing America (DA) spends only 6% of its GNP.(1)

Death rates from heart disease and cancer are higher in NA. Death rates from infectious diseases, heart disease and respiratory diseases are higher in DA. Death rates from car accidents are equivalent.(1) The prevalence of AIDS in NA is 46/1000 versus a wide range of .3/1000 to 40/1000 in DA. Deaths from AIDS related cases in NA rose to 11th place on the death chart.(1) Twenty-seven (27%) percent of all deaths from AIDS occurred in the Black community. A distinct racial health gap exists in NA. Only 3% of NA physicians are Black. There is an excess of deaths of Blacks from cancer, cardiovascular disease, stroke, diabetes, drug dependency, and infant mortality. Black males have a disproportionately higher incidence of hypertension, diabetes, cancer and eye diseases.(2)

In NA, 7.5% live below the poverty line vs. 37.0% in DA(poverty being defined as the state in which one can not afford the basic necessities).(1)

Access to supplies and facilities in NA due to more advanced transportation and simple geographical proximity is far more available than in DA.

These are different environments with different

histories and resulting different cultures, currently subjected to different strains and expectations. The types of patients with regard to diet, physical nature and mental attitude are very different. In NA, only 5% of the drugs used are for the digestive system vs. 12% in DA, thus reflecting, in part, the social significance attributed t the art of eating and drinking.(3)

IV. Attitudes...

The Old World(Europe) has always considered the New World(the Americas) to be savage and uncivilized. This misconception persists. The European descendants in the New World still view anyone with brown skin and/or a non-English accent as outside of their "way of life" and therefore, subordinate. Albert Schweitzer:" The African is indeed my brother, (but) my junior brother."(3) To the NA white establishment, the non-white doctor is an incomplete doctor, even if he or she has identical training and credentials. Foreign medical schools are still considered inferior to those in NA no matter how many dedicated and successful physicians and medical staff they produce. These are ingrained prejudices concerning race and ethnic origins which are prevalent throughout both NA and DA, and involving both doctors and patients. A patient, Black or white, sees a Black doctor and there is immediate suspicion as to qualifications and competence. White patients usually address the issue directly, either by seeking only white

doctors or by questioning the ability and experiences of the non-white doctor. The white doctor sees a Black or Hispanic patient with abdominal pain and assumes that the diagnosis will be that of a sexually transmitted infectious disease, (PID or pelvic inflammatory disease). These are medical assumptions based on appearance and previously existing prejudices.

The American army surgeon, Dr.Walter Reed is usually credited with having founded and developed the cure for Yellow Fever in Cuba, during the Spanish-American War of 1898 and little mention is made of the native hosts, Dr. Carlos Finley and Dr. Jesse Lazeer, who were far more familiar with the disease and no doubt did most of the background work.(4) Who is most competent to recognize and treat a particular disease than the one who is most familiar with it, given all else as equal.

In NA, medical training and practice relies heavily on technology and aggressive treatment. Doctors are not known for their clinical skills in examination and diagnosis of the patient, but are known for their inattention to bedside observations and too much attention to laboratory tests, a concept known as overdoctoring.(5) A patient in NA is 15 times more likely to undergo surgery for a specific ailment than is his or her counterpart in DA. Caesarian sections for births, super-radical mastectomies for breast masses, invasive

examinations, tonsillectomies, lensectomies for early cataracts and other prophylactic surgeries are the rule. Sixty (60%) percent of hysterectomies are done on women less than 44 years old. Widespread vaccinations are done on all children for Rubella rather than on just those susceptible prepubertal females.(3) The "Frontier mentality" which led to the conquest of NA persists in the medical field in that anything is possible and can be conquered, usually by taking it out or eradicating it, rather than by adding to it to increase the body's resistance to it.(3)

Dr. Benjamin Rush, a Civil War surgeon and influential sage on American medicine, believed "that one of the hindrances to the development of medicine had been an undue reliance on the powers of nature in curing disease." He therefore relied on massive purging and bloodletting to cure Yellow Fever.(4) The NA directive is that "desperate diseases require desperate remedies." This is not always the case. Recent studies have shown that cancer patients receiving different therapies involving surgery, radiotherapy(radiation), chemotherapy(drugs) and homeopathy(use of small doses to increase resistance) had the same outcome in terms of survival time and effectiveness.(2) Despite theoretical teachings

directed at consideration and treatment of the whole patient, the aggressive use of stronger drugs, higher dosages, more radical surgery and further tests have become the hallmark of NA medical practice. The Type A personality is prevalent among NA doctors with an emphasis on prestige, wealth and social position. The patient as a complete person is too often lost in a sea of laboratory tests and SWAG(scientific wild-ass guess)sessions.

Patient demand has had an impact on the attitude of the medical practioner. Multiple drugs and extensive surgery are expected and requested. Antibiotics are prescribed simply if a bacterium is present, a practice which has led to an increase in the development of resistant strains. Aggressive overuse of drugs can lead to extensive side effects which can be more serious than the original disease itself. All physicians and a great many patients are aware of this but tend to accept the overtreatment anyway.

The attitude that more is good and still more is better is firmly established. A triple bypass heart surgery elicits more prestige and takes more courage to undergo than a simple wart excision. The patient who "beats" cancer through more extensive treatment modalities is considered more superior than one who fights it and loses. Both are

infinitely better than one who refuses to fight it at all. Gastrectomy and extensive intestinal resection is more heroic than taking Maalox and following a proper diet.

Therefore, attitudes in NA medicine are shaped and dispensed in terms of victory and ultimate conquest through aggressive treatment and invasive techniques, which are part of its history and national characer.(3)

The threat of malpractice suits has had an enormous impact on the attitude of doctors and patients in the medical world of NA. The law requires that everything possible be done for the patient as is customary within the confines of the particular jurisdiction. It has become imperative to intervene and to do something rather than to do nothing at all. Errors of commission are more acceptable to a jury than are errors of omission. Yet statistics show that the majority of errors are made as a result of commission.(3)

The gross misallocation of health funds has led to a continued neglect of the poor, the elderly and the dispossessed. Millions of dollars are spent on artificial hearts but comparatively little is spent on preventive medical care. Medicare covers only those diseases than are considered as curable. Medical spas are considered

nonconventional and unnecessary. Nursing homes are disgraceful. Since results are demanded and expected fast, NA is not very adept at treating chronic diseases. With the high tech attitude towards death and dying, it takes a court order for one to be allowed to die with dignity.

The DA patient's notion that everything is better in NA can easily be altered by experiencing the practice of "patient dumping" by NA hospitals. If one does not have the means by which to pay, basic and even emergency care are refused at certain hospitals. It should be noted that some 35 million Americans are without adequate health insurance.(2) There are many nations that make up the DA and each has its own specific features that sets it apart from another, but the similarities of origin and culture make it possible to group them all together for purposes of delineating the general characteristics of medical practice. Throughout the DA, physicians are more apt to practice traditional medicine and assist nature in making the cure. This is due in part to the lack of availability of the technology so predominant in NA, but also is deeply rooted in custom and tradition. The family often accompanies the patient to the doctor, absorbs every word and attempts to take an active part in carrying out the treatment. Extended family living takes precedence over remote nursing homes. The physician's attitude is also based in part on

tradition, but is highly influenced by location and exposure. Isolation from or proximity to teaching hospitals, supporting house staff, availability of current medical literature, mass media disclosures and economic and political organization of the health system all play an important role in shaping the attitude and practice of the DA physician.

The presence of tradition combined with religion leads to a more heightened awareness of the patient as an entity with a history and a soul, rather than as a machine to be oiled and repaired when it threatens to break down. The DA physician and patient can not be evaluated by the same criteria that is used in the NA system.

A Hispanic female presents with symptoms of hysteria and anxiety and is given increasing doses of drugs by the NA psychiatrist. She does not improve and instead returns to her native country and begins visits to the local espiritista or curandera (fundamentalist minister). She improves. The cultural background and prior experience will determine both the patient's and the doctor's comprehension of the problem. Traditional methods of healing are often

dismissed by North Americans as being part magic and part psychosomatic...anesthesia through acupuncture works on animals too.

The characteristics of stress-related and mental illnesses will vary across cultures so much that Schizophrenia in the DA has a higher cure rate than in NA.(6)

Physicians in the Developing Americas rely more on clinical acumen in making diagnoses in that the high tech tests and treatments are not readily available or are not economically affordable. Patients' demands and expectations are not as high. There is more trust in the physician's ability and in the powers of the unseen to bring about a cure. There is stronger bonding in the patient-doctor relationship as seen in the custom of bringing personal gifts to the doctor and staff in addition to monetary compensation. Both doctor and patient pay more attention toward the emotional characteristics surrounding the disease entity. Disease takes on a dual nature as resulting from a combination of some type of outside insult coupled with the inner body's reaction to that insult. The spirit and the soul of the body are addressed and assuaged as part and parcel of the whole condition and treatment.

Different countries have variable definitions of the same disease. The heart in NA is regarded merely as a pump, while in DA it also contains the soul and harbors the emotions. This may be part of the reason for the failure of the artificial heart.(3)

The differences attributed to language are obvious. In NA multilingual physicians are scarce and non-English speaking patients often suffer from additional lack of clarity of their disease in being unable to express their symptoms and hence become the victims of the all-encompassing laboratory tests.

V. Conclusion

Small towns need small town doctors. Treatments regarded by one culture as effective may be regarded by another as marginal and ineffective. The results should examined and only then can intelligent decisions be made. It is wrong to say that the treatment that the patient receives in one culture is "better or worse" than in another culture. The variables are many and must be realized as being dependent on an individual's needs, perceptions and expectations. Medical practice should not impose a single world view. NA physicians need to remove the blinders of scientific medicine, pay more attention to unscientific patient desires and discontinue their widespread disregard and disrespect for culturally defined illnesses and treatments. We need enlightened doctors and educated patients who can blend high tech with cultural diversity. Differences must be recognized and choice instituted. This choice should result from human desire and not from pure science.

In the Developing Americas the technological base must be widened. This will involve large scale improvements in economics and politics. Modern biomedicine can work along with other healing systems if the primary aim remains the reduction of human suffering and enhancement of the quality of life, free of greed and commercial gain, and without ignoring the culture necessary to provide the individual with vital social and psychological support.

Observing and respecting medical care in other countries can widen one's own perspectives and understanding of disease processes, use of treatment modalities and assessment of resulting effectiveness. The broadest and most effective practice then becomes an anthropologically informed or a cross cultural biomedical practice.

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