The Cultural Divide between Medical Providers and Their Patients — Aligning Two World Views

by Sara E. Tirrell

Medical providers and patients, like all people, perceive and understand the world through cultural media, and often do not belong to the same culture. A medical/ nonmedical biculturalism is needed to ensure that patients receive effective communication about their diseases, and sufficient education to respond to western medicine's ability to heal or ameliorate their illnesses.

Anthropologist James Lett (1987) states, "All human beings perceive and understand the world through the medium of their culture." Both the patient and the medical provider bring their unique cultural perspectives to each encounter in the lab, clinic, or doctor's office. Without a common understanding, it is unlikely that any of these encounters will be a success.

Many healthcare workers are bound by their medical culture, and patients cannot understand their confusing language or diagnoses. It is vital to bridge this cultural gap by communicating with a common language, using ideas understood by both. Through clinical examples I will demonstrate how this divide is created from the cultural backgrounds of the provider and the patient and discuss the complications of translation services for non-English speaking patients.

Understanding Culture

Edward B. Tylor, a famous anthropologist, defined culture as "that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society" (Tylor 1973). This normative concept, which began in 1871, viewed culture as something that is gained or lost depending on the level of civility a person or a group possessed. This generalization is still operative when culture is viewed as something we attain through experience or education. However, it is now more prevalent to use culture as a descriptive term to explain the way a group of people live and function together as a whole.

Although several definitions fit the descriptive concept of culture, I view it as Roger Keesing does — as "the system of knowledge more or less shared by members of a society" (Keesing 1981). Shared knowledge among a group of people helps create a common language through which they will participate in social practices and uphold a specific belief system. Such cultures will have rules and systems to maintain their beliefs and sustain their knowledge. In short, each culture will have a distinct world view that only its members fully understand. These life components ensure that members of the culture will experience reality in a way that nonmembers do not. (Lett 1987)

The Medical Culture

When looking at Western medicine through an anthropological lens, it is clear that only those members who share its "system of knowledge" can be part of its practices, understanding, and belief systems. Thus, medicine is a subculture. A provider's diploma or office may attest his or her specialty, but it does not define him or her as a member of the medical culture; for that, one must adopt medicine's way of looking at the world. Undergoing medical treatment is one way to enter the culture, but some patients are also members. Their immersion in it comes through listening to, and absorbing, the world view of their providers.

Thus, for example, after many years of monitoring their condition, chronic diabetic patients begin to understand the way their bodies function when it comes to sugars and insulin. Their personal involvement brings them into the medical culture. Their view of medicine may be through a narrow scope of illness and healing, which only focuses on diabetes, but this knowledge is sufficient for admission to the culture. It not only explains their illness, but also the medical system as a whole and its many intricate parts. If one of these diabetic patients were to be diagnosed with cancer, he or she will develop a new vocabulary to speak with that healthcare team while still operating within the medical culture based on previous knowledge. Becoming a member of the medical culture requires little more than the ability to discuss illness and healing and a capacity to function within the system.

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The Nonmedical Culture

The distinction between the medical and nonmedical cultures may take many different forms depending on the patient's world view. Our society contains several subcultures juxtaposed to western medicine's cultural reality. Patients may seek the increasingly popular forms of alternative medicine for a variety of reasons. Perhaps western medicine creates a financial burden, or perhaps some patients do not trust doctors or their healing methods. Still others may have experienced the medical culture's inability to cure some illnesses (Gordon 1996).

Indeed some patients living outside the realm of the medical culture may never have sought medical treatment in the western sense. Although medicine is an integrated part of mainstream culture in the western world, many people have never visited a doctor. Some of these patients may have chosen to cope with illness in other ways, while others may have lacked the resources to use western medicine. Still others reject modern medicine because they feel that too much medicine will exhaust their bodies or because they don't see its usefulness.

Other patients who seek alternatives to western medicine may be looking for a more spiritual world view. Many people both inside and outside the medical culture attribute illness and healing to divine sources. Yet some providers may perceive these ideas as challenging or disrespectful, and feel that it makes their work more difficult. Such providers often lack empathy for patients outside the medical culture.

How the Cultural Divide Is Created

Consider a twenty-two year old, upper-middle class female who subscribes to the dominant American culture. A description of her annual check-up can provide insight into the perspective of most mainstream North Americans. Before entering the physician's office, she is nervous. A seemingly healthy individual, she still feels the anxiety of the unknown.

Once she arrives for the office visit, a doctor she may or may not know asks intimate questions. She admits to her general health, how much she drinks, how much she smokes, whether she is sexually active, if she uses contraception, if she is under stress, and why. These questions come within the first few minutes. Then, gowned in paper, the patient must relax for the doctor's examination, during which he or she will probe the patient's body and learn the secrets of her life. Naturally, most patients are not entirely comfortable with this interaction.

Imagine, now, the cultural aspects of the visit, which may create a distinct boundary between the physician and the patient. The doctor may use medical jargon, which excludes the patient and adds to her personal discomfort. As a member of the dominant culture, the patient believes in the benefits of western medicine, so despite her discomfort, she is willing to learn more about her health and submit to the medical culture's ideals. However, her lack of comfort marks her as an outsider. If this patient represents mainstream society and a willingness to subscribe to the medical culture, the cultural divide will be that much wider when patients from the nonmedical culture enter the physician's office.

Once the medical and nonmedical cultures bifurcate, we must consider the effect this division has on patient interaction and patient care. The significance of culture is immeasurable because "no matter how hard man tries it is impossible for him to divest himself of his own culture, for it has penetrated to the roots of his nervous system and determines how he perceives the world" (Hall 1966). Therefore, when a physician attends an ill patient, he or she sees the illness as most western-medical healers would see it, whereas the patient may view the same illness through a different paradigm. Kleinman, Eisenberg, and Good (1987) wrote precisely about this divide in their discussion of the differences between disease and illness. Thus,

> "Disease in the Western medical paradigm is malfunctioning or maladaptation of biologic and psychophysiologic processes in the individual; whereas illness represents personal, interpersonal, and cultural reactions to disease or discomfort."

Personal and Cultural Responses to Illness

The stories that follow concern both English and Spanish-speaking populations. In both groups the disparity between the medical and nonmedical cultures is evident. The English-speaking patients obviously have more in common with most doctors through their use of the same language. However, this fact does not imply that they easily understand and relate to their healthcare providers. Hispanic patients have a more formidable barrier in terms of language, which is especially significant when they are forced to communicate their pain and receive the doctor's advice through a third person in translation. Hispanics face the medical/nonmedical cultural barrier, linguistic barriers, and North American versus Latino cultural barriers. In these examples of everyday family practice, the need for providers to be bicultural becomes evident.

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The Alternative Medicine Patient

An upper-middle class woman was diagnosed with gallbladder cancer and given a terminal outlook for the months ahead. Like many other cancer patients, her disease could not be cured by western medicine due to the advanced state of her condition at diagnosis. Her healthcare team did intervene with pain management, continually

trying to increase the amount of medication she was taking for her comfort during the duration of her disease. Her cancer had metastasized throughout her body. This woman did not want the complications of western medical treatments to dominate the end of her life. Despite numerous interactions with healthcare, she chose to live and function outside the medical culture and her perception of its shortcomings. She sought alternative methods to decrease her symptoms such as massage therapy for muscle aches and distraction therapy to keep her mind in a healthy state. Instead of strong pain medications, she wanted the least obtrusive methods of pain management. If she agreed to take morphine, she knew she would not be able to control her thoughts.

Although she understood and had access to western medicine, she chose an alternative that suited her ideology. She continually stated that she did not want to live her daily life taking a host of medicines.

Her first choice of a treatment regimen included juicing, a natural diet to support the body's immune system allowing it to function at the highest level possible, while hopefully killing cancer cells. Belief in this treatment stems from the nature of cancer: since it is an overgrowth of cells that the body's immune system does not control; juicing attempts to boost the immune system allowing the body to kill the deadly tumor cells.

This woman's desire to try alternative cancer treatments expressed her hope to conquer the disease, her lack of access to conventional medical treatments because of the advanced stages of her disease, and her willingness to be treated outside the medical culture.

Although she understood and had access to western medicine, she chose an alternative that suited her ideology. She continually stated that she did not want to live her daily life taking a host of medicines. When confronted with a situation where western medicine could be helpful, she sought a more natural alternative to reach the same result. Laxatives were replaced with smooth-move tea, a natural over-the-counter laxative. She believed that if these things worked, she would be less reliant on pills and medication.

The First-Time Patient

A second example of a patient in the nonmedical culture is one who lives without seeking medical assistance. For providers this attitude can be difficult to comprehend. It means seeing patients who have never visited a doctor and who don't function in the realm of western medicine's beliefs regarding illness and healing.

A thirty-two-year-old Hispanic woman came to the clinic for a follow up visit for stomach pain and to review her lab results from the previous week. The physician assistant explained that the blood analysis found her to have the stomach bacteria H. pylori. The patient simply looked at her and asked, "What is bacteria?" Suddenly the provider was being asked to explain a concept that she and her colleagues simply take for granted. She began to describe how small colonies of living things found in all our bodies can become harmful when they grow out of control. But taking antibiotics can control the bacteria, heal the stomach, and relieve her symptoms.

This abstract and strange concept seemed like science fiction. If a patient doesn't understand bacteria, a fundamental premise of western medicine, how can we expect her to believe that antibiotics (yet another foreign concept) will cure her? The cultural barrier is not merely explaining a term such as "bacteria." To become compliant, the patient must believe that the medicine will, in fact, cure her, which begins with a belief in her diagnosis. Here medicine faces a cultural division

created by its boundedness to its own "system of knowledge."

Translation Barriers

Another obstacle for Hispanic or other non-English speaking patients is linguistic, rather than cultural. That is, it stems not from their unfamiliarity with medical concepts, but with their need for a translator. The linguistic barrier is of concern as hospitals and medical practices strive to use staff and translation services to better to communicate with all patients. The role of the interpreter in the medical culture is both complex and subjective, presenting ethical complications.

When providers must speak their message through an interpreter, the message becomes more an interpretation than a translation. The meaning is maintained, but the message is changed to make sense in each respective language. When the message goes through a third person, that person must internalize the meaning, understand it, and formulate it into another language. The words are no longer the doctor's or the patient's but the interpreter's.

Many times the doctor's words become less medical; for example a "prolapsed uterus" becomes "the uterus has fallen" in Spanish. Provider and interpreter are in essence describing the same thing; however, if translation changes a simple phrase, we must wonder what else is being said differently. One translator states that she "says [the doctor's message] in a way that the patient will understand what is wrong," though not necessarily in the way that the doctor said it. This approach actually appears to be the more effective way of interpreting. When translators say exactly what the doctor said, patients may have a difficult time understanding.

As I am not a native Spanish speaker myself, I often listen to other translators to see if my word choices are what a native would say. My translations are more like the provider's speech and less natural in the Hispanic dialogue. For example, a nurse practitioner told a patient to go to her appointment with a full bladder. The native Hispanic translator said, "drink a lot of water before going to your appointment, and then don't go to the bathroom until the doctor says that you can." I asked her why she didn't just say, "go with a full bladder to your appointment." She stated that both are correct, but my translation was too formal. She would rather say the doctor's message in an approachable manner while maintaining the meaning of the directions.

The amount of trust given to a third party is a dilemma that comes with the use of translation. Neither providers nor patients can be sure that their words are being heard as they intended them to be.

Translators often find themselves playing the role of cultural broker. This term refers to a bicultural person who can advise both parties when communication becomes difficult. It helps providers understand the native perspective in addition to just asking the usual medical questions (Fadiman 1997). This role carries a sense of authority because the interpreter now becomes an expert in his or her own culture. However, this authority can also be dangerous.

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For example, when a nurse practitioner asked a Hispanic woman at the clinic if she did her own self-breast exams, the interpreter responded that Hispanic women don't do self-breast exams and did not translate the question. The provider insisted that she ask the patient, and the patient replied that she did in fact check her own breasts monthly. Interpreters overstep the limits of effective translation when they assume that all members of the same culture will maintain similar

practices and beliefs. Providers must glean the information they need to practice medicine; however, a cultural broker may be especially useful when patients of vastly different cultures appear to be at a standstill with western medicine. Gaining a background in the beliefs of the patient allows medicine to be practiced more effectively (Fadiman 1997).

The Need for Biculturalism

While I was translating for a twenty-six-year-old Hispanic woman, the doctor told her that she had a yeast infection, which I translated as a "vaginal infection" because I did not know a commonly used Spanish word for yeast infection. Immediately she became worried as to what kind of infection it could be. She wanted to know if it was contagious to her husband, and how she got it. We assured her that it was not a sexually transmitted disease, but a simple infection caused by an overgrowth of yeast, which is a naturally present fungus in the vagina.

Seeking to confirm my translation, I later asked four Hispanic translators if I was correct to merely say she had a vaginal infection. They all agreed that there are no other words for it. It just is a vaginal infection. I still felt unsettled, realizing that the patient is at a disadvantage if she cannot fully understand her condition. We have different names for vaginal infections so that women may know what is wrong with them. Say, for example that the patient goes home and tells her husband that she has a vaginal infection. What complications could this bring to the marriage if she is not able to explain the infection to her spouse? She deserves to know exactly what she has, not only for her own personal knowledge, but also for her husband's peace of mind.

This case exemplifies the need for biculturalism. The provider must explain the patient's illness so that she can understand it, but also to educate her about the infection and how to cure it. Biculturalism is the idea that a person can function equally well in the two different cultures. It is important for providers to maintain their medical expertise, which is why patients seek their advice. However, they must also learn to approach their patients in a nonmedical way. A nonmedical approach to patient care can help shrink the gap between the two cultures.

Several studies have been conducted on methods of inquiry such as Kleinman's "explanatory model" for a patient-centered approach (Kleinman, Eisenberg, and Good 1978). This work suggests that doctors be required to incorporate some social science into their curriculum so that they can better relate to their patients. These are bold and necessary movements in medicine but more must be done to help providers become more culturally diverse and better equipped to explain diseases to their patients.

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We must not only seek to understand the patients' perspectives on their illness; we must also try to educate them about how the medical culture understands their disease. In practicing medical/nonmedical biculturalism, we can transform the medium of culture from an obstacle to a method of providing effective patient care.

Conclusion

The profession of medicine is a calling to serve the afflicted. Healthcare providers work every day to alleviate pain and suffering for their patients; however, the divide created between the medical and nonmedical cultures often prohibits providers from effectively dispensing this aid. Medicine is a subculture with unique practices, language, and beliefs about the human body based on a shared "system of knowledge." Providers operating within their own medical culture will have difficulties being understood by those patients who have distinct nonmedical world views. These two cultures must commune through the efforts of bicultural providers.

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