LEARNING FROM PATIENTS

MISSING: A FORESKIN, A DIGIT AND ... CULTURAL PERCEPTIVENESS

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Many postgraduate Family Medicine programmes around the world encourage students to 'learn from patients'. This often requires reflection and self-examination from the student, discussion with colleagues and mentors, and further reading.

In South Africa, doctors are often confronted with situations in which our patients' requests, understanding of problems and solutions are derived from different beliefs and world views. Local sociologists and anthropologists have spent years documenting cultural differences. As general practitioners, we are uniquely placed to report on some of these from the perspective of the consultation.

The following story is one example.

PART 1

I FIRST SAW THE LITTLE FELLOW WHEN HIS PARENTS, who had recently arrived in town, requested a circumcision because of a narrow foreskin. The child was 18 months old. However, on examination, I could find no sign of phimosis. I successfully (I thought) reassured the parents that a circumcision would not be necessary.

At the next visit, the mother again requested a circumcision. I was somewhat amazed. I explained that there was no medical reason for doing the procedure. It would be purely for 'aesthetic' reasons and would furthermore require an anaesthetic. She reaffirmed the request.

My partner, who did the pre-operative anaesthetic assessment in the presence of both parents, became aware of some discord between them. It seemed that the mother was not entirely happy about the procedure, but was acceding to her husband's decision.

Sure enough in theatre, who should come along with the child but the father. He insisted on staying for the operation – which didn't bother me. I don't get much satisfaction from doing circumcisions. I used to find using the clamp a bit hair-raising – worrying that one day I'd find the glans hadn't completely retreated from its sharp edges. (Two bigger boys wandering around our town with somewhat generous remnants of foreskin are walking testimony to this fear.) I'm now much braver and will happily pull the foreskin well forward – clamp firmly – and slice off the unwanted tissue.

The piteous sight on removing the clamp always reminds me of a truncated Cornish pasty. This was made worse in this instance as the little boy was slightly obese. His penis virtually disappeared into his pubic area. If I hadn't been used to this procedure, I know I would have panicked.

His poor father, however, sagged against the walls of the theatre and slumped to the floor, head held between his hands. I imagine he knew he would have to face the consequences of his little boy's disability and his wife's wrath till his dying day.

As swiftly as I could, I peeled back the

remaining foreskin to reveal a handsome glans to the prostrate father – who then perked up considerably. The reason for his anguish in theatre became more obvious when we returned the drowsy little boy to his waiting mum. She burst into tears, both in distress that the procedure had been done at all, and with relief that the child was essentially unharmed.

PART 2

SEVERAL MONTHS AGO MY PARTNER ASKED ME what I would do with a four-year-old boy whose parents had requested amputation of the terminal phalanx of the fourth finger of his left hand. We were both familiar with the fact that this was a tribal custom in one or more communities in our area, but had never before been asked to get involved. I was unaware of the background to the custom or whether different reasons for it existed.

My immediate reaction to the request was negative: there was no recognised medical reason that I knew of to suggest I should carry out the procedure. Removing a normal part of someone's body for the sake of someone else's peculiar customary beliefs didn't feel right to me, and it didn't fit in with any conventional medical norms.

I didn't think to ask at the time why *we* were being approached instead of the normal, 'traditional' procedure being performed. My partner concurred with my opinion. As neither of us was prepared to help, the parents were left to their own resources.

A few weeks later they returned with a very sick little boy minus part of his finger. He also had trismus, extreme irritability and the beginnings of opisthotonus. He ended up in the ICU at our regional hospital where fortunately he survived the ordeal, but was left with some residual contractures of his limbs.

TWO REFLECTIONS:

1. In the first story, having 'done my duty' in explaining that the circumcision was not medically indicated, I was unperturbed about going ahead simply upon request. I neither explored the reasons behind the request nor really considered the mother's feelings. Verbal and non-verbal clues offered during the consultations preceding the operation were ignored. The mother's fears, and the family pressure and constraints under which the father may have laboured, could at least have been acknowledged had I taken these into account.
2. In the second story, almost on reflex I refused to perform the amputation. Finding out the family's reasons for consulting us never entered my mind.

These stories illustrate how much my personal bias influenced not only my decision-making, but the manner in which I approached these similar requests. I was unaware of the extent to which this bias would negate any attempt at patient-centredness.[1]

In the first patient my bias towards infant circumcision was tempered by its being an accepted procedure in my own culture. This interfered with a patient interview taking place which may have promoted better family understanding and parental accord.

In the second patient, my bias against the procedure again focused my attention totally on my own agenda to the complete exclusion of that of the parents.

TWO QUESTIONS:

1. The stories illustrate incidents where my biomedical outlook and cultural upbringing affected the patient outcome. How many other less dramatic, yet equally important patient interactions are affected in the same way on a daily basis? What might I do to transcend my own culture, or subculture, to form a more positive therapeutic alliance with each of my patients?
2. Ethical issues are involved in complying with patients' requests which are out of the 'ordinary'. Let's say I come to terms with the idea of amputating terminal phalanges, but then one day discover the reason for wanting the amputation is as a punishment for theft. What would I do then? (This isn't a far-fetched scenario.)

I've since questioned patients with missing digits and had various explanations as to the reasons. The most common reason given is clan identification; another is to stop repetitive petty theft. Yet another is to cure adolescent enuresis; and in one 24-year-old patient, it was for menstrual problems and primary infertility. (The treatment was successful.)

I asked myself the question – how do I enhance a therapeutic or healing relationship with patients from different cultures, subcultures or even different family cultures? Understanding how my own culture affects the way I think, is a starting point.

DEVELOPING CULTURAL AWARENESS

1. Viewing other people's ways of life through my own cultural 'glasses' is called ethnocentrism.[2] (Perhaps it could also be thought of as 'cultural myopia'.) Everything with which I interface (events and relationships) is filtered through this perceptual screen. I am usually unaware of how this screen influences me and therefore consider my own patterns of behaviour as the norm. I demonstrate the effect of this whenever I think or talk about the behaviour of people from other cultures as being 'weird', 'primitive' or 'strange'. The underlying implication is that I think of my own culture as 'right' or 'better' and not just 'different'.[2]
2. Cultural factors shape the way people react to disease and it is useful to recognise that this reaction manifests and presents as the 'illness'. As people ***learn ways of being ill*** from the family and community, it follows that disease will manifest differently in every culture. This conceptual difference between disease and illness is important. Put more formally, disease – according to the western medical paradigm – is the malfunctioning or maladaptation of biologic and psychophysiologic processes in the individual. Illness, on the other hand, represents the personal, interpersonal and cultural reaction to disease or discomfort.[3]
3. Traditional healers are often successful within their own communities in that they provide meaningful explanations for illness, and respond to the personal, family or community issues surrounding illness.
4. As a doctor my own understanding of a patient's 'illness' is coloured and distorted by my cultural perceptions. My biomedical background tends to focus on the 'objective', and may discount the 'illness experience' as a legitimate clinical component of the presentation.
5. For me to change this is not easy. It involves removing my own cultural lenses and creating an empty space[4] where I am open to 'foreign' world views, and different perceptions and models of illness. According to Fehrsen, one needs to become 'detribalised' in order to see the relativity of one's own culture and to learn to value other peoples' cultures. He describes it as 'walking softly and humbly, as you are meeting an expert'.[4] As I understand this, it does not mean 'giving up' one's own cultural view but rather having a respectful, open attitude towards others.

DEVELOPING SELF-AWARENESS

1. According to Hall, the first step towards becoming more culturally aware is to become more self-aware.[2] This is often not achieved without personal struggle and pain. In any setting, if I am to have a constructive and affirmative therapeutic relationship, it is important that this is not compromised by behaviour that originates in unexamined personal issues,[5] (and many of our cultural issues are certainly subconscious and unexamined).
2. One of Longhurst's[5] suggestions is to examine the reaction of others to ourselves. Reflecting upon our own life experiences also generates enormous self-awareness. And, Longhurst adds, opening ourselves up to the humorous aspects of life's events provides a perspective that gives balance.
3. In my own practice I have found my staff are a good source of information in cross-cultural interactions. They tell me about reactions of patients and provide other insights. This type of feedback is enhanced by my listening respectfully, non-defensively and with appreciation. I also try to change my attitude or approaches according to the insights they provide.

My interpreter is also a wealth of information regarding the customs and expectations of Xhosa-speaking patients. How much is shared is dependent upon the interest I show. At times inviting direct feedback from the patient on the 'content' or 'process' of the consultation has improved my self-awareness, and seems to have increased patient satisfaction.

HOW THIS HELPS ME

In reflecting upon my own biomedical background I am beginning to realise how culture-specific and value-laden it is. My

definition of 'clinical reality' is limited to fit into disease categories. To be able to treat and cure I need to try to fit my patients' symptom complex into one of these categories. This explains why I struggle to accommodate ideas such as: what the patient's illness **means** to him or her, how illness may occur in the absence of disease, or how one may successfully treat disease – yet find that the illness remains. Patients of course have their own models of explaining illness[6] which usually are in conflict with my model. This helps me to understand why, even after I've given my explanation of the illness, including its treatment, the patient may not share my view. Problems of non-compliance are but one manifestation of this discrepancy in understanding.

Kleinman and Smith have outlined the kinds of useful questions that may be asked to elicit a patient's view and understanding of the illness.[6] One is then in a much better position to discuss the assessment, using layperson's terms or the patient's own conceptual idiom. This may allow one to engage in negotiation and arrive at a mutually acceptable explanation and management of the illness.

Why did the parents in my second story seek intervention from western medicine for a traditional procedure? I assume their belief that this thing had to be done was unshakeable, because they were prepared to step out of their normal way of going about it. They may have agonised over this decision for a long time before deciding it was the right thing to do. Perhaps they had high hopes that we would understand their tensions, fears, and the difficulties associated with the issue. It's possible they were afraid of inflicting pain on their son, and felt he was too young really to understand why he should suffer. They were perhaps even afraid of infection – possibly having seen a bad result previously or having experienced one themselves. Whatever the case, I imagine I would have found a lot of common ground between myself and this family had I adopted a more 'ethno-medical' approach.[7] This would have had an impact upon my reasons for not wanting to comply with their request – possibly allowing me to compromise.

Conclusion

In summary, had I been less arrogant and able to step out of an ethnocentric professional framework, I could have participated far more meaningfully in these families' lives, cultures and immediate problems.

Nevertheless, I am aware that occasions may arise when I will honour the 'absolutes' of my personal belief system above the 'requests' of my patients – but, hopefully, I will then do so consciously rather than as a conditioned reflex.

Dr Miller has been in family practice in a rural Eastern Cape town for 10 years.

References:

1. Henbest RJ. Patient-centred care: a review of the concept. S Afr Fam Pract 1989;10:454-63.
2. Deagle GL. The Art of Cross-Cultural Care. Can Fam Physician 1986;32:1315-8.
3. Kleinman A, Eisenberg L, Good B. Culture, Illness, and Care. Clinical Lessons from Anthropological and Cross-Cultural Research. Ann Intern Med 1978;88:251-8.
4. Fehrsen GS. Bridging the cultural gap. Paper delivered at WONCA, Jerusalem 1989.
5. Longhurst M. Physician Self-Awareness: the neglected insight. CMAJ 1988;139:121-4.
6. Smith CK, Kleinman A. Beyond the Biomedical Model: Integration of Psychosocial and Cultural Orientations. In: Taylor RB ed. Fundamentals of Family Medicine. New York: Springer-Verlag, 1983:88-97.
7. Henbest RJ. Time for a Change: new perspectives on the doctor-patient interaction. S Afr Fam Pract 1989;10:8-15.