Human Resources

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American medical students broaden their horizons in the Third World

Every year for several decades some American medical students have been visiting Third World countries in order to participate in the practices there. These experiences have proved invaluable in helping them to work in the USA among minorities having unorthodox views on health and disease.

Although United States medical schools have been providing opportunities for students to carry out clinical rotations in developing countries for at least 40 years, there has been no systematic documentation of the educational consequences. However, there appears to be a widespread conviction that these visits have beneficial effects on the personal and professional qualities of the participants. The gains are said to include: improved confidence in knowledge, history, and physical examination as the basis for diagnosis and treatment; improved skills in the diagnosis of undifferentiated complaints; greater appreciation of the health consequences of economic and political policy; enhanced awareness of costs; and enriched understanding of the clinical significance of cultural factors in the presentation, diagnosis, course, consequences, and management of illness (1-4).

In 1984 the Department of Family Medicine in the State University of New York at Buffalo began a programme of clinical rotations by students to developing countries. By means of a questionnaire, data have been collected from returning students, the principal aim being to identify the clinically significant features of culture in health and medical care. Questionnaires from 30 students have been analysed, representing clinical rotations by mainly senior medical students in various developing countries since 1984.

The students were typically supervised by Western-trained, usually American, primary care physicians. Most of the sites were visited by the first author to communicate training goals and discover the chief
characteristics of the working environment. Among the most frequently used sites were: Tumu Tumu and Kikuyu hospitals in Kenya; Emkhuzweni Health Centre and Raleigh-Fitkin Hospital in Swaziland; and the refugee camps on the Thailand-Cambodia border. Students usually remained on site for six to eight weeks and experienced both inpatient and ambulatory services.

Rather than relying on a formal definition of culture we have used the categories most frequently employed by students in describing cultural influences on the presentation, course, and management of illness: language and communication; religious beliefs; marriage, family and sexual relationships; psychosocial issues; disease concepts; and death and dying.

Although the importance of doctor-patient communication had been impressed on the students during training, their actual experiences did not encourage them to take it too seriously.

Increased consumer sophistication has brought a growing desire for a collaborative relationship between patient and physician. In Western society the rising proportion of chronic problems and the recognition of the influence of behaviour on health have strengthened this trend. Yet the notion of doctors giving orders remains deeply embedded in Western culture and is virtually unchanged in many rural and urban populations neglected by health care systems. Upper middle class medical students in urban training environments tend not to see the clinical consequences of one-way communication because:

— among the more sophisticated patients it is relatively subtle;
— the relationship of medical students with less sophisticated urban and rural patients is limited and episodic;
— the truncated involvement of students with patients obscures even the short-term effects of one-way communication.

In Third World settings the students saw clearly a problem they tended to ignore in their home environment. Communication barriers due to differences in both formal language and world view prevented patients from being equal or even junior partners in their treatment or health maintenance. In witnessing at first hand the heightened effects of one-way communication, the students were impressed with the critical importance of the doctor-patient relationship. As one student remarked, "... a health partnership could be beneficial—prevention is far less expensive than cure."
The virtual impossibility of achieving real rapport when working through an interpreter did little to establish a bond of confidence. Patients consequently tended to seek alternative doctors, including traditional healers. This frustrated the students but taught them the clinical importance of rapport and trust.

**Religious beliefs**

Religious and magical belief systems excluding biomedical concepts of disease placed traditional healers on the first line of intervention. This led to patients presenting themselves much later than they ought to have done for medical intervention. The students, despite their frustration, recognized that this was attributable to belief systems that differed from their own rather than to stupidity or culpable ignorance.

Some students encountered populations who believed a bulging fontanelle was an open mole and a sign that the victim was possessed by an evil spirit; to exorcise it, the custom was to shave the affected area and rub it with chalk, the medical consequence of which was a presentation with late-stage meningitis. In parts of north-central Tanzania, tradition blames flies for a variety of internal disorders, the insects supposedly gaining entry into the body through ingestion, aspiration or the curse of an enemy; the remedy is to ingest and subsequently regurgitate a milky liquid from which the healer invariably retrieves the offending insects.

Such beliefs and behaviour were recognized by the students as cultural variations with major implications for health care. Less extreme but comparable beliefs are often attributed by doctors in developed countries to ignorance or stupidity.

**Marriage, family and sexual relationships**

Polygamy and polygyny are widely accepted cultural values but are practiced by a minority in any society. For most men a second wife is a costly and complicated luxury. This becomes especially true as cash cropping and urban employment replace subsistence farming. For men, sexual relationships with multiple partners out of wedlock are encouraged by tribal traditions. The adverse effects on health are amplified by mobility and urbanization. Among the consequences are the extensive occurrence of sexually transmitted diseases and spontaneous abortions. Even if treatment for women is readily available it has little impact since men repeatedly reinfect their partners.

In addition to maintaining the home and often the farm as well, a woman is traditionally expected to bear children throughout her reproductive years. Despite changed conditions which mean that large families are seldom economic assets, fecund women and large families are still highly regarded. Yet multiparity causes high levels of maternal and infant mortality and morbidity.

It was disturbingly common to come across healthy fathers with malnourished wives and children. The men ate first, their wives and children got what remained. Since the supply and variety of food was often poor,
the students repeatedly encountered malnutrition caused by environmental and domestic factors that were aggravated by cultural norms.

Husbands often resisted or refused hospitalization of mothers or wanted them to care for their children while in hospital. The pressure on hospitalized wives to return to their domestic responsibilities was intense, often resulting in premature discharge. Against this background it became very clear to the students that it was important to negotiate rather than simply to issue instructions.

Students were often shocked to see relatives move into hospital with patients. This was no quaint custom but often the only way that adequate feeding and maintenance could be accomplished. Under these conditions the students quickly came to appreciate that medical intervention could not achieve its potential in the absence of family support. They also realized that the same reality holds in the developed world.

Mothers neither sought nor expected health care if they had very young children or during harvest time, except in what they considered to be acute emergencies. Competing demands for domestic order and sometimes survival tended to defer or cancel medical attention. In the Third World, family constraints cannot be ignored if medical intervention is to be effective. They may be life-and-death issues that the physician has to respect.

**Psychosocial issues**

The seeming indifference to time, planning, and so on among many people in the Third World reflects an existence where they have little control over their destiny. Under such conditions, living for the moment is an entirely rational tendency.

Stoicism was a consistent response to deprivation and suffering but created problems for medical students when patients presented themselves at late stages of disease with preventable complications. The students recognized this as a legitimate and appropriate cultural pattern.

Stress-related psychosocial problems were extensive but were frequently ignored or accorded little attention by both patients and students, largely because so much time and so many resources were claimed by overwhelming pressures of acute life-threatening conditions. Furthermore, there were few intervention tools in community clinics. The traditional healers, however, did tackle such problems, and the students saw that they were often quite effective. Through their ceremonial ministrations the healers gave problems names, causes and validity. They enabled patients to express their distress, mobilized family and community support, and restored hope. These are universal elements in effective psychotherapy (5).

Patients typically associated an absence of overt physical signs and symptoms with non-medical problems. Students readily saw the parallel of this perception with beliefs shared by patients and physicians in Western society.

People with mental illness and retardation which had no obvious physical manifestation
and were not curable by healers were often stigmatized. Adults and children with such conditions were at best tolerated, at worst shunned and left to fend for themselves. Frequently, those who survived were reduced to living on the streets as beggars. This was not simply callousness—unproductive children and adults are a threat to the survival of others in precarious economic circumstances. Indeed, some students found the situation more understandable than the plight of street people in Western society, where resources are comparatively enormous. Perhaps the most significant lesson concerned the severe demands on the emotional and material resources of families resulting from conditions that were disabling but not fully accepted as legitimate illnesses.

The students observed in extreme form something that is common but more subtle in Western medicine: non-physical problems were not considered the province of the physician. Many psychosocial problems were consequently presented as physical complaints so as to legitimate them. The students not only recognized the diagnostic and management difficulties posed by this practice but also learned that such behaviour was not simply attributable to ignorance or mistaken perceptions.

Disease concepts

The apparently irrational behaviour of many Africans in ignoring symptoms, reinfecting themselves or others, failing to follow prescribed treatment, and avoiding treatment altogether can often be linked to a concept of illness sharply different from the Western biomedical model. Where the germ theory has no currency there is unlikely to be much enthusiasm for treatment or prevention. From the perspective of a relatively sophisticated medical student this negative behaviour reflected dangerous ignorance but commanded sufficient respect in the particular context to warrant attention rather than impatient dismissal.

Death and dying

Students and other clinicians were continually confronted by deaths that could have been avoided if the right equipment and treatment had been available. The frequency of deaths gave rise to instructive responses on the part of patients and their families. Death was not usually discussed in cases of terminal illness nor was the subject introduced by doctors or patients in hospitals. This might have appeared to be a form of denial but societal and familial responses suggested otherwise. Even though preparation for death through frank discussion—the fashion in American culture—was conspicuously absent, patients seemed to accept death with resignation if not serenity. For families and patients, death was a commonplace experience and was handled with dignity. Dying patients, especially if elderly, were typically cared for at home by their families. The lack of discussion with medical personnel probably reflected the view of death as a normal event in everyday living. It was a family affair where doctors were simply irrelevant.

American students and physicians working in their home environment frequently encounter members of subcultures whose traditions and beliefs differ from their own. Typically, the differences are attributed to ignorance on the part of patients or are dismissed as a nuisance. Students working as a tiny minority in an alien culture, however, tend to accept unfamiliar world views as legitimate even though they may be
technically incorrect. This attitude is conducive to efforts to accommodate the differences and use them to therapeutic advantage. Despite obvious frustrations this approach is far more productive than the cultural evangelism often unwittingly practised by physicians serving minorities in the USA. On the basis of their experience in cultures different from their own, the students clearly felt that there should be a softening of wasteful confrontational attitudes.

The students clearly considered that cultural sensitivity was as important as the traditional competencies in the clinician’s repertoire. This view was a direct consequence of working in a sociocultural environment where the biomedical paradigm carried little weight. The students considered that the components of culture with the greatest impact on clinical matters were: language; religious beliefs; marriage, family, and sexual relationships; psychosocial issues; disease concepts; and death and dying.

Why should it be necessary for American students to visit Africa and Asia to find educationally valuable cross-cultural experiences? The same lessons are available within a short distance from almost any medical school in the USA but students are more willing to go abroad for the sake of adventure and education than to travel across their own town for either. It is not the responsibility of medical educators to accommodate this inclination but we can take advantage of it. Students will undoubtedly continue to make working visits to developing countries. We can get the most from these experiences if we understand their educational yield. A more rational approach to screening, preparation and evaluation should follow. Perhaps such visits could become an integral component of medical curricula.

References


