To PUBLIC CONSULTATION ON GOOD MEDICAL PRACTICE

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MEDICAL CARE IN DEVELOPING COUNTRIES

A Primer on the Medicine of Poverty
and
A Symposium from Makerere

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Based on a conference assisted by WHO/UNICEF, and an experimental edition assisted by UNICEF

Published with a grant from the Ford Foundation, through the 'East African Teaching Materials Fund'

Nairobi
OXFORD UNIVERSITY PRESS
Lusaka Addis Ababa London
1966

Chapter Four

THE CROSS-CULTURAL OUTLOOK IN MEDICINE

Maurice King

4:1 **'Culture'.** Though it is all around us the most important parts of our 'culture' remain invisible to us. As we slowly reach our full thoughtfulness and maturity inside it we inevitably absorb it unawares; whether we like it or not we are the product of it. Only when we have reached a high level of education, and obtained something of the insight of the comparative sociologist or social anthropologist, can we see our own culture for what it is, and understand where it differs from those of other communities.

But what is this abstraction 'culture'? It is the sum total of the customs, beliefs, attitudes, values, goals, laws, traditions and moral codes of a people. It includes their language and their art as well as everything they make, be it a stone axe or a spacecraft. It includes their corporate view of the universe and also their attitudes to health and disease. In all these dimensions does the culture of a people like the pygmies of the Ituri forest differ from the culture of the commuters of New York city. The reader will say that this is obvious, and in a limited sense so it is. The American doctor practising among the pygmies will immediately see that in such things as language, dress and education his patients differ from those he looked after in North America. But these are only the obvious and visible parts of a culture. Its values, attitudes, traditions and morals are invisible and not nearly so obvious.

The almost inevitable human tendency is to accept the visible parts of a strange culture, and unconsciously graft on to them invisible elements from the observer's own culture, albeit in a very incomplete and haphazard way. A real understanding of the invisible elements of another culture, and even more so of one's own, requires training, effort and great openness of mind. Unless he is watchful the doctor will tend to assume that his tropical patients know about the spread of infectious diseases and put the same value on the possession of money or cows as he does. He may know that witchcraft exists, but disregard it, because it plays such a small part in his own culture. This compounded view of a strange culture — 'the visibles of the strange culture plus some of the invisible elements of the observer's own culture' — is the common view of the educated but sociologically untrained person contemplating a culture new to him.

4:2 **The value of a 'cross-cultural' outlook.** Few doctors, even in developed countries, practise among patients who are culturally similar to themselves, and this is even more so in developing ones which typically contain so many varied tribes. If this cultural difference between a doctor and his patients is granted, how necessary is it that he understands their culture, and obtains what might be called 'a cross-cultural outlook'? It may be argued that penicillin works similarly whatever the culture of the patient, that a post-partum haemorrhage requires the same treatment anywhere in the world, and that the signs of mitral stenosis depend only on disordered physiology. This is true, and it must be admitted that many doctors have practised with some success, and even achieved academic eminence with hardly the faintest understanding of the way their patients look at the world. But their success is partial and perhaps their eminence is undeserved. If medicine is to be more than just the application of technique, and indeed even if it is to be merely the efficient application of technique, then the patient's culture must be understood as it relates to their health, and in practice it is found to relate at a great many points. Why will they not give their blood for transfusion? (23:2) Why, when their children are malnourished, will they not use the protein sources that seem readily available? (14:2) Why are they so loath to accept family planning? (18:5) Why is it so difficult to persuade them that tuberculosis is infectious? (6:12) Why is gonorrhoea so prevalent in the area? All these questions and a great many others may only be explicable in their cultural setting.

4:3 **Obtaining a 'cross-cultural' outlook.** If it is granted that a cross-cultural outlook is necessary, how can it be obtained? How can a doctor, as it were, get inside his patient's culture and see the world as they see it?

The first step is to realize that the cross-cultural problem exists, and that active measures are needed to discover and understand a strange culture.

The next is to observe the culture closely. Why does a child patient wear such a peculiar necklace of skin and bits of hair? Has it been

supplied by the traditional healer, and, if so, what is the system of beliefs on which it depends? What are those peculiar herbs the patient's relatives are cooking so busily in that pot? Why do the women wear dresses which bear such a remarkable resemblance to those fashionable in Europe in 1890? Why is this adult literacy class composed mostly of women? Is it because by learning to read these women seek to gain influence over their illiterate husbands? Why are the words 'Sea never dry' written on the tailboard of that 'Mammy wagon'? These are just some of the visible starting points from which the invisible aspects of a culture can be built up by careful question and enquiry. Some of them have no obvious relation to health, yet they are well worth following because an overall view of the culture is necessary if those parts of it which are relevant to health are to be seen in their true context.

Those about to practise in a strange culture should make a point of reading whatever published work is available on the local community. Thus, Southall and Gutkind's book *Townsmen in the Making* /124/, is a classical and easily readable study of the sociology of urban Uganda and *Igbo-ora, a Town in Transition*, is a more recent account of a somewhat similar kind from Nigeria /19/. Oscar Lewis's book *Children of Sanchez* /93a/, will provide vivid insight into the culture of the common man in Mexico. Though they have wider application, these are only local studies, and a textbook of medical anthropology for developing countries is greatly needed. In its absence the popular works of Margaret Mead will provide some background knowledge /96/. In a few developing countries, the local novelists and playwrights provide useful insight into the culture. This is especially true of Nigeria where the works of Chinua Achebe and Wole Soyinka will be found very instructive.

Thanks to endeavours of anthropologists, many of the world's cultures have now been fairly adequately studied, and if a particular tribe has not been examined, there is likely to be an account available of a closely similar one. Hitherto, the readership of works in this field has been small and some accounts may be hard to obtain, but if local studies can be found they may well make interesting reading.

Similarly, if there are anthropologists working in the area they may have much to tell doctors working with the same tribes. Once they have learnt the local language and been accepted by the people, they are likely to be a good source of information on customs relevant to health. They are unlikely to have the information available in a very accessible form, but it should not be too difficult to elicit from them.

Educated members of the community, particularly the hospital staff, are another source of information on the local culture and here again careful questioning will be needed. Care must be taken to account for the bias of the informant, who may try to cover up what he feels ashamed

of, be ignorant of what actually happens, or be incapable of conveying the true state of affairs, even if he knows it.

Lastly, but most important of all, there are the patients themselves. Besides observing them carefully, the critically important step is to learn their language, but time is short, languages are diverse, postings from one part of the country to another are often frequent, and few doctors acquire new languages with sufficient facility to enable effective two-way communication to take place. Sometimes there is a language like the Nigerian 'Pidgin' which makes communication at a certain level very easy, but interpreters have usually to be used. But working through an interpreter is time-consuming, and it is convenient to know a few clinical questions in the vernacular to which the expected answer is 'yes' or 'no', such as 'Have you got a cough?' or 'Is there blood in your sputum?' Even more useful are what might be called the clinical imperatives, such as 'Take a deep breath' or, 'Say aaah'. A few dozen phrases of this kind, and especially the local greetings, must be considered the minimum knowledge of the local language for clinical efficiency. On being posted to a place where the language is strange it is well worth making a list of the phrases and learning them. The reader could hardly do better than translate into his local vernacular the phrases compiled by Strover and Mazorodze in their *Shona Phrase Book* which is published as a supplement to the December 1965 issue (Vol 11, No. 12) of the *Central African Journal of Medicine*. Here at least is the basis for a planned interview, and a foundation upon which a working knowledge of a language can be built.

Even so, there will be many occasions when interpreters will have to be used, and sometimes, if the language is a very unusual one, two of them will be needed working together, one interpreting to the other. Try to make sure that the interpreter himself understands the question and that he does his best to make sure that the patient does so too. Get in the habit of insisting on being given the answer to the question asked and not the answer to a different one. Once the answer to a different question is accepted further logical interrogation becomes impossible.

But this has been a digression. The important point, as far as this chapter is concerned, is, that when histories are being taken, some questions should be asked which relate to the patient's general culture. This will enable a clear picture of their society to be built up steadily over the years. In every community the doctor is in a uniquely favourable position to study his fellow men, because, with due care, he can ask almost any question he likes in the name of medicine.

Some early steps in the study of a culture. Even the simplest human society is enormously complex and the novice can be pardoned for not

knowing where to begin. Large numbers of individuals play many different roles, they interact with one another, with their physical environment and with other societies in intricate and ever changing ways. The following list contains just a few of the things that have to be known in the description of every human community. They are the sort of questions to begin by asking and form some of the more obvious dimensions of a culture. Further lists are recorded in connection with health education and malnutrition in sections 6:9 and 14:2.

Method: A start in the study of a strange culture.

The Family. What are the common patterns of family composition? What is the age of marriage and how stable is it? What are the strongest emotional ties within it? What are the obligations towards the extended family of uncles, aunts, and cousins? What is the status of women?

After the family, what other important associations are there? Political parties? Guilds? Agricultural co-operatives? Initiation groups? Religious communities?

Who are the influential members of the community? Chiefs? Party officials? School teachers? Ministers? Hospital assistants?

What accords status in the community? Cattle? Wives? Children? Land? Money? Education?

What are the values of a community? Leisure? Conformity? Happiness? Fulfilment of the personality?

What are the customs of the community over the use and ownership of land and money? How is the land inherited? What is the income of the average family? Is money the common property of the family? Is there money available in the community for medical expenses?

What are the attitudes and practices of the community in matters of health and disease? What is the traditional system of medicine? Do people consult their healers first, or only after scientific medicine has failed? What are the concepts of causation of the common diseases? Does the indigenous system of medicine include the idea of prevention? What are the local names for the common diseases?

The practices of the community on matters of health can be divided into three groups, those which are beneficial to health, those which have no effect and those which are positively harmful. It is their effect on health that matters, not their strangeness to the observer nor their

remoteness to his own culture. Some practices may seem very odd indeed and yet be either harmless or even actually helpful. Thus, the habit that mothers in some cultures have of prechewing their infant's food and giving him the masticated material straight from their own mouths is not to be discouraged; it is likely to be harmless and may even be beneficial. Mother and child share the same bacterial flora anyway, and part of the child's digesting will already have been done for him.

4:5 **Some useful sociological concepts.** This is no place to go deeply into the structure of human communities, but here are certain ideas that are well worth bearing in mind.

A culture is a logically integrated dynamic whole and is not merely an accidental collection of customs. Looked at overall it makes sense, and, unless great changes are taking place, most cultures are fairly harmonious. But, because a culture is in equilibrium, a major change in one part of it is likely to cause multiple changes elsewhere, for the old balance will now be changed. For example, the assumption of professional or middle class standards of life is at variance with the traditional idea that many cultures have of the obligations to an extended family. The desire for a higher standard of living may lead to the limitation of family obligations, and this in turn may produce further changes, such as less security in sickness and old age, and lessened responsibility for the education of nephews and cousins.

A culture makes it possible for the members of a society to interact with one another in a more or less automatic manner. As they grow up its members learn the behaviour expected of them in the innumerable roles they will have to play in life, whether as sons, fathers, employees, lovers, buyers, students or professors, etc. This stereotyped activity of a stable culture is a great convenience, for it makes interaction between one individual and another so very much simpler. In an unstable or changing culture these roles will be changing too, and its members will be without the security of knowing the exact behaviour that is expected of them in each social situation.

All culture is learned by one member from another. For many individuals the learning process is complete once childhood is past, and it is only the minority of adults who are likely to learn new forms of behaviour. But this minority is of great importance, because, if we can only identify the few people who are susceptible to being taught and teach them, then the society can in time be introduced to new patterns of behaviour.

In most communities there are a few individuals to whom the rest look up. These are often, but not always, the natural leaders of the group such as chiefs, priests, schoolmasters and doctors. If these can be iden-

tified, and it may be more difficult to identify the women leaders in communities where their status is relatively low, they are the people who are most likely to be effective in spreading a change in behaviour through the group.

Every society has a few individual members who are inventors or discoverers and their activities are one of the reasons for the fact that no culture is ever quite static. But the main reason for cultural change is not a community's own inventors, but its power of absorbing the inventions of other cultures. Thus the scientific industrial culture of developed countries has in the past absorbed an immense wealth of invention from the civilizations which preceded it, coinage and the wheel to mention only two. It in its turn is now being absorbed by the traditional cultures of the pre-industrial countries at a very rapid rate. This meeting of the two cultures, the scientific and the traditional, is so extensive, and they are so profoundly opposed on so many issues, that the stress resulting can best be described as 'cross-cultural conflict' (13:1).

In this cross-cultural conflict, in which the indigenous doctor is likely to be involved quite as much as any of his patients, it is natural that the health aspects of the clash should be uppermost in his mind. Nevertheless, a doctor is well placed to observe the whole process of social change, and, though there may be little any individual can do to modify it, a doctor has a uniquely influential position in the local community.

It is suggested that he be guided by the following principles which determine whether a change in the culture is to be encouraged or discouraged. Inevitably, any attitude in this matter is deeply influenced by the observer's own values. Too often, the individual is powerless and principles often conflict, but despite this some guidance may be useful.

Other things being equal, any social change is likely to be beneficial which does the following:

(a) Promotes harmonious social interaction and cohesion of any lawful kind between individuals; that is, anything which promotes 'togetherness' or 'community'. Thus, unless there are compelling reasons against them, clans and societies, rites and rituals, etc. are all to be fostered.

(b) Enables the individual to realize his innate potentialities; this includes any kind of education.

(c) Preserves or enhances the uniqueness and creativity of the group. Thus, art, in any form, folk tales, local languages and customs are to be preserved as valuable components of the total achievement of our species.

When two cultures meet it is unusual for one to displace the other completely, a more common result is for elements of the two to fuse in some way, the process being given the name of 'syncretism'. For example,

in societies where scarification or tatooing is done with non-medical intent, it is possible for the populace to interpret the scientific process of vaccination merely as an addition to their present beliefs and not as an entirely different concept. Should such a process of integrating scientific medicine with the local beliefs be encouraged or discouraged? Opinions differ, but most workers would probably agree that it is better to get a desirable practice adopted by this means than not to get it adopted at all.

4:6 **Summary.** Before summing up there is one final message to leave with the reader. This is the importance of learning from the culture being studied. One thing that compels admiration in so many tropical societies is their intense sense of community (20:2). This is surely *the* critical ingredient in human happiness, and how far removed from, and how infinitely preferable it is to the loneliness and social fragmentation of the industrial suburbs of Europe and America. The incorporation of deep and vigorous community life in a technological society is widely held to be one of the major problems of our age.

Method: Obtaining a 'cross-cultural outlook' in medicine.

Observe the society closely. Use what is visible to lead to what is invisible in terms of attitudes, values and goals etc.

Read some anthropology.

Read what novels and plays may be relevant.

See if there have been any specific studies of the tribes in the area and read them.

Make the acquaintance of any anthropologist working in the vicinity.

Obtain an insight into the local culture by carefully questioning some of the more educated members of the local community.

Follow this up by obtaining more information in routine case histories taken from the patients.

Take at least some steps to learn a local language, even if it is only the greetings and the necessary clinical questions and imperatives.

Lastly, all the world's cultures are equally fit for study, be they those of affluent technocracies or pygmy aborigines. Anthropology is the study of man in all his variety, and is in no sense limited merely to the study of remote and barbarous tribes. It has been rightly said that anthropology is not merely 'barbarology'.

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To whom it may concern

I am submitting comments on the current public consultation, viz: : 'Public consultation on Good medical practice' to medboardconsultation@ahpra.gov.au by close of business on 3 August 2018. The comments are confined to sections 4.7 and 4.8 below as I only found out about the consultation in the past few days and did not have time to review other aspects.

Medical Board of Australia

4.7 Aboriginal and Torres Strait Islander Peoples' health Australia has always been a culturally and linguistically diverse nation.

Aboriginal and Torres Strait Islander Peoples have inhabited and cared for the land as the first peoples of Australia for millennia, and their histories and cultures have uniquely shaped our nation. Understanding and acknowledging historic factors such as colonisation and its impact on Aboriginal and Torres Strait Islander Peoples' health, helps inform care. In particular, Aboriginal and Torres Strait Islander Peoples bear the burden of gross social, cultural and health inequity. In supporting the health of Aboriginal and Torres Strait Islander Peoples, good medical practice involves:

4.7.1 Providing care that is holistic, free of bias and racism, challenges belief based upon assumption and is culturally safe and respectful for Aboriginal and Torres Strait Islander Peoples.

4.7.2 Advocating for and acting to facilitate access to quality and culturally safe health services for Aboriginal and Torres Strait Islander Peoples.

4.7.3 Recognising the importance of family, community, partnership and collaboration in the healthcare decision-making of Aboriginal and Torres Strait Islander Peoples, for both prevention strategies and care delivery.

4.8 Culturally safe and respectful practice

Culturally safe and respectful practice requires you to understand how your own culture, values, attitudes, assumptions and beliefs influence interactions with patients and families, the community, colleagues and team members. Good medical practice is culturally safe and respectful. This includes:

4.8.1 Understanding that only the patient and/or their family can determine whether or not care is culturally safe and respectful.

4.8.2 Respecting diverse cultures, beliefs, gender identities, sexualities and experiences of people, including among colleagues and team members.

4.8.3 Acknowledging the social, economic, cultural, historic and behavioural factors influencing health, both at the individual, community and population levels.

4.8.4 Adopting practices that respect diversity, avoid bias, discrimination and racism, and challenge belief based on assumption (for example, based on gender, disability, race, ethnicity, religion, sexuality, age or political beliefs).

4.8.5 Supporting an inclusive environment for the safety and security of the individual patient and their family and/or significant others.

4.8.6 Creating a positive, culturally safe work environment through role modelling, and supporting the rights, dignity and safety of others, including patients, colleagues and team members

COMMENTS ON THE ABOVE SECTIONS

- My main comment is that these sections are not written in a style that is appropriate for a Code. They seem more like a contentious lecture to students in a Sociology faculty and as a health professional (clinical pharmacist-retired) I found the tone and content quite patronising. I do not deny that cultural factors can impact on patient care and would suggest the following to replace both the proposed 4.7 and 4.8:
  "Doctors dealing with patients of an active cultural background different from their own should be aware that aspects of that culture may impact on patient care. Doctors are required to take steps to understand these differences and incorporate that information into their professional dealings with such patients.

- The proposed 4.7 and 4.8 seem to be aimed at doctors of white Australian native background and hence are not inclusive of all doctors practising in Australia. For example, do they apply to an Aboriginal doctor, or medical graduates trained in Australia from India or China? Are 4.7 and 4.8 a denial that we Australians have our own culture that foreign born doctors don't have to consider when treating us? There is no mention of that. My suggested generic replacement covers all those questions, and that's how a code should be.
- As part of their continuing education requirements doctors should be encouraged to attend in-services or conference programs that deal with this issue. It is not hard to do. In May 1968 I was working as a hospital pharmacist in Zambia and on one weekend I attended a Medical Conference at the City of Kitwe. It was put on by the Zambia Medical Association – Congo Border Division. On sale at the conference was a book entitled "Medical Care in Developing Countries – A Symposium from Makerere – Edited by Dr Maurice King". It complemented the issues being discussed at the Kitwe conference, including those of a clinical and cultural nature. Dr King includes a whole chapter devoted to cultural factors entitled "The Cross-Cultural Outlook in Medicine". This chapter was much appreciated by expatriate health professionals newly arrived in Zambia. I will forward a copy of the chapter for your information.
- [redacted]

[redacted] Despite telling her that it had been an infection, her belief system was so strong that she was discharged still believing that the cause of her problem had been witchcraft. To me that is a classic example of how doctors should take into consideration the cultural backgrounds of their patients. In relation to our own Australian culture viz-a-viz medicine I gave a paper in the 1990s on traditional Zambian (Bemba) medicine to an African Studies university group. The word for medicine in Bemba is "muti" which is the same word for a tree. All parts of the tree – leaf, bark, root etc were used either as an infusion to be taken orally or as a powder to be rubbed into the skin where small cuts had been made with a sharp implement. [redacted] Even today in Australia there are people of strong religious faith who retain such beliefs.

- Of course, people whose non European migrant ancestors had particular cultural medical beliefs but who have been in Australia for several generations would be expected to share the wider Australian cultural aspects of medicine, [redacted]