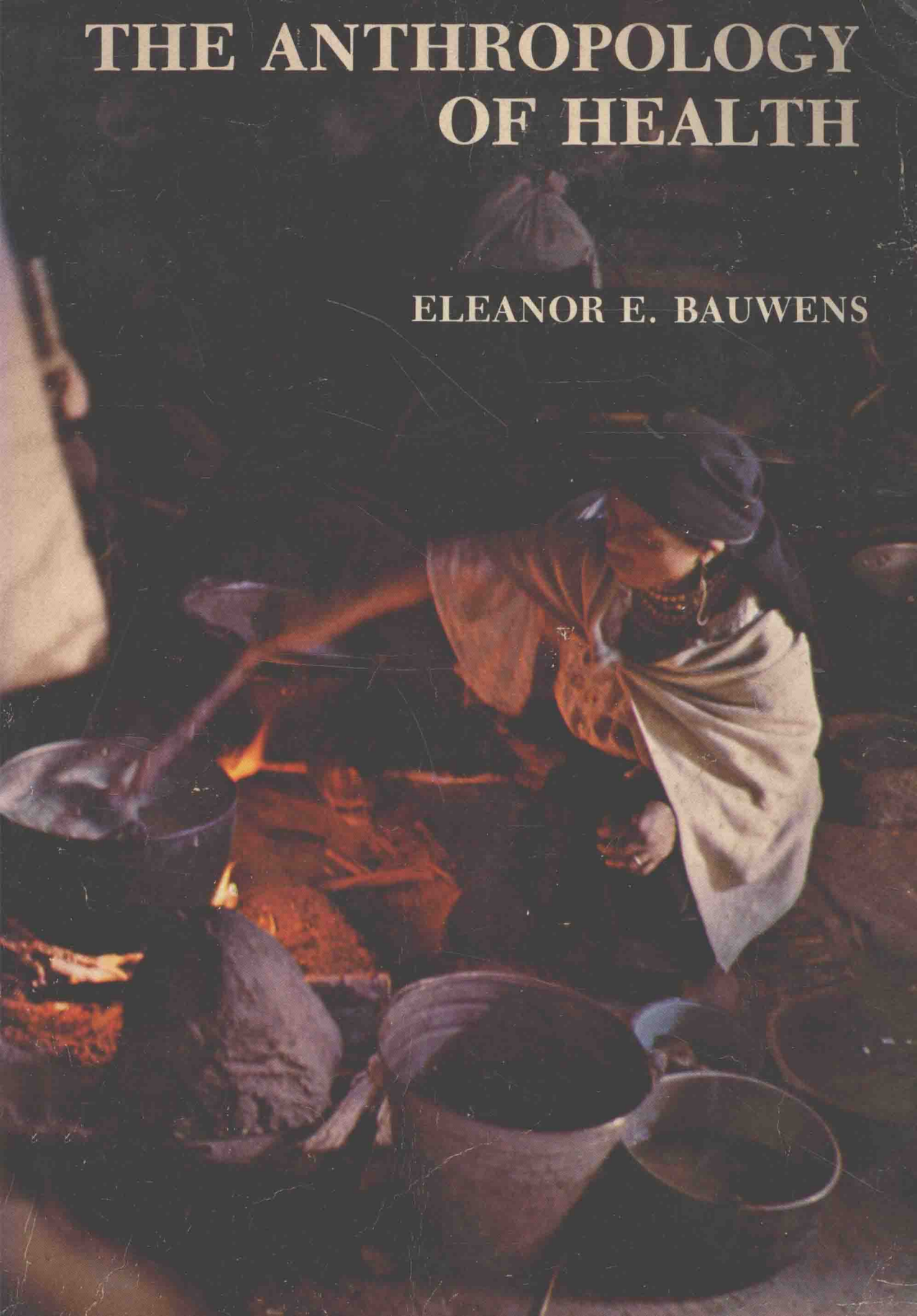
THE ANTHROPOLOGY OF HEALTH

ELEANOR E. BAUWENS



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Illustrated

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PREFACE

Several related influences have prompted me to organize a group of papers concerning the place and relationship of anthropology within the broad spectrum of the behavioral and health sciences. My experience with the difficulty involved in finding an adequate book for both students and colleagues is the most immediate influence. The growing importance about the desirability and necessity of incorporating anthropological concepts within other disciplines such as medicine, nursing, and public health reflects a need for a volume such as this.

There is an increasing need to communicate to a broader audience the many facets of anthropology. Members of the health professions are beginning to extend their knowledge about health beliefs, practices, and needs of individuals from different cultures. As these professionals take a more active part in providing health care to people from diverse cultures, it becomes essential that they attempt to increase their understanding about these cultural groups.

The purposes of this volume are to contribute to the educational process of preparing more individuals for specialized work in the field of medical anthropology, to contribute to the development of literature in medical anthropology, and to introduce behavioral science to medical, nursing, and other health professions.

This volume includes original research and theoretical papers that attempt to bridge anthropological and medical perspectives and methods contributing to a science of illness and health care. Included are discussions of how the concept of culture is operationalized in anthropology and the health sciences. Chapters are organized into four sections: (1) Clinical Anthropology, the relation and application of anthropological principles to health care; (2) Strategies for Health Care, the attempts to relate medicine to culture, society, and health care programs; (3) Nutritional Anthropology, the discussion of the sociocultural value attached to various foods by various groups and the concern with changing the food habits in different cultural settings; and (4) Anthropological Perspectives on Aging and Dying, the discussion of the sociocultural aspects of aging and dying.

For help in locating authors and for various suggestions regarding the book, I should like to express my gratitude to Margarita Kay, Loudell Snow, and Jane Underwood. In addition, I should like to thank both Margarita Kay and Michael Rich for reading portions of the manuscript and for sharing with me their critical comments.

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Eleanor E. Bauwens

CONTENTS

PART ONE

CLINICAL ANTHROPOLOGY

Chapter 1 explores clinical anthropology, which is the application of principles of anthropological theory to the practice of patient care. The principal message of medical anthropology has been that medical culture patterns are not isolated, but rather integrated into a complex network of beliefs and values that are part of the culture of each society. Prevention, diagnosis, and treatment of illness follow more or less directly from beliefs about causation. Thus the anthropologist has tried to learn what people know, believe, and do with their lives in order to discover the logic underlying health and illness behavior. However, clinical anthropology requires more, for health care behavior may be determined by the relationship of individuals to the social structure of the dominant society, their economic positions, and biological factors.

Chapter 2 illustrates how clinical anthropology can be the bridge between traditional methods of treatment and folk medicine. This chapter presents a case history of abdominal pain in an 11½-year old Mexican-American female.

Chapter 3 is a selected review of the literature of interest to both anthropologists and health professionals. Chapter 4 examines the cultural dimension of the concept of care and suggests alternative strategies for research. The assumption is made that all cultures provide a system of rules for caring for oneself and/or others, and that health specialists can advance health and patient care when they understand these rules.

Chapter 5 focuses on a study done in a prenatal clinic with a multi-ethnic low income clientele. The women informants document the reasons why they have been unable to prevent their pregnancies.

Chapter 6 discusses an adaptive strategy utilized by women for dealing with their dissatisfaction with hospital births and hospital maternity care in general. Home births have been chosen as a way to reduce the dissonance that occurs with hospital births.

Chapter 7 looks at the health and healing practices among five ethnic groups residing in Miami, Florida. Patterns of use of both orthodox and traditional healing systems among these groups are discussed. The goal is to develop models for more appropriate health care delivery.

CHAPTER 1

Clinical anthropology

Margarita Kay

1. Mrs. Jackson is black. Let's see her about root medicine.
2. You can give them the best diagnostic work-up and treatment, but they won't even come back to cooperate.
3. You can't teach them prevention, not of babies or of disease. They are fatalistic, you know, they're in the culture of poverty.
4. We've got some Papago blood samples left over from that diabetes study. Why don't we just send them in to the laboratory to see if they have antibodies to Chagas disease?
5. The man in room 7 is refusing to let the student nurse bathe him. How can we give good care if we let patients make decisions about what we do?
6. Mrs. Begay hasn't come into the intensive care nursery once to visit her baby. It sounds like she is rejecting him.

The above statements may appear to be egregious cases of cultural ignorance. In fact, they are typical of occurrences that may take place daily in any medical facility. They are examples of why clinical anthropology, the study of anthropology applied to patient care, should be offered to health care workers. The first statement illustrates the misconception that any member of an ethnic group is expert in all aspects of that culture, and that anyone can do an anthropological study without special training. Furthermore, the statement ignores the possibility that an individual might be reluctant to discuss something so easily misunderstood as root medicine with an outsider. It ignores personal interest and other differences, such as social class and education, which might make Mrs. Jackson ignorant of root medicine.

The second statement is common. Why don't people comply with carefully designed courses of diagnosis and treatment? The reasons are legion, but the most common is lack of communication between health care provider and client.

The third statement ascribes social reasons for cultural phenomena. Although culture and life-style are often treated as if they were identical, there is more than a theoretical distinction between the two categories. The lifestyles of people in poverty are varied, with economics the only factor held in common. Thus social scientists have discarded the idea of a single culture of poverty as an explanation for health-seeking behavior. But there has been a continued uncritical use of this concept, probably stemming from frustration at noncompliance. Such action by some health care professionals has distorted the organization of clinics and other health services and wasted the time and money of all.

The fourth statement is an example of how two cultures can view the same entity—blood samples—in two distinct ways. To the physician, the blood is simply laboratory material, conveniently available for study. To the Papago, the blood represents individual people who cannot benefit from learning about a disease that gives them no symptoms.

In example five, the nurse assumes that the phenomenon of care is the same for all people. The nurse assumes that touch, space, motion, soap, and water have the same meaning and the same effect on everyone.

The sixth example might reflect an accurate appraisal of a specific individual. However, the chances are great that the statement simply reflects cultural ignorance, a lack of knowledge of a different mode of nonverbal communication, which is another dimension of care.

Examples such as these pointed up the need for a class designed to apply principles of anthropology to the practice of patient care. This chapter will describe my experience in teaching a course called clinical anthropology, cross-listed for students in anthropology, family and community medicine, and nursing, which is the home department. Students also come from nutrition, physical therapy, occupational therapy, pediatrics, gerontology, and other health fields. Similar courses are offered in many other colleges and universities, but none has been described in the literature for comparison, emulation, or criticism.

THE CLASS

In my course that portion of anthropology that is immediately relevant to health care in the southwestern United States is surveyed. Thus clinical anthropology is not the same as medical anthropology, for topics such as paleopathology, primitive medicine, biological adaptation, and sexual selection are omitted because they are not obviously germane.

Many health care providers have stated the need to take cultural factors into consideration in health care. These commendable but vague statements are not put into action very often, because the scholars of culture have given little practical help. The goal of my course is to show how the nebulous ideal of "taking into account the patient's culture" may be met. There is an attempt to introduce applied anthropology.

Shiloh (1977:444) states that "too much of applied anthropology is still dilettante do-gooding, too much of action anthropology is still underdog advocacy, and too much of medical anthropology continues to be Naive Victoriana," and suggests a new role for the anthropologist, that of a private practitioner of therapeutic anthropology. Even without developing a new professional in health care, it is beneficial to help existing providers of care to remove their cultural blinders. Many know only the ethnocentric medical model that represents Western science today.

The heterogeneous composition of the class is believed by all members to be beneficial. At first, undergraduate nursing students are timid to find themselves as classmates of practicing physicians, and require encouragement not to drop out. The physicians in turn may be concerned about handling cultural data that they find to be unfamiliar, ambiguous, and "soft." The class variation immediately provides an opportunity to illustrate that what is commonly called "the" health system is in fact not shared culture. Caste relations, minority behavior, and different cultural knowledge can be explored as each health care giver learns what the other knows.

Students are told that the purpose of the course is to give training to professional health care workers and anthropologists in topics of mutual interest. In order to solve clinical problems that are not primarily biological in nature, lectures are addressed to questions such as:

1. Who are the people seeking health care in the Southwest?
2. What does one need to know about a people in order to assist them in health care?
3. Which methods are most useful for learning aspects of life-style and culture that influence health behavior?
4. How may elements be organized into a model for studying any medical system?

It is expected that the students' objectives reflect their own professional needs. Physicians should be aware of cultural factors if they are to prevent as well as diagnose and treat disease. Nurses need to know cultural factors to understand health-seeking behavior and learn culturally appropriate ways to assist patients who cannot care for themselves. Anthropologists need to know official scientific medicine's point of view as well as how to apply anthropological theory and data to health problems.

At the beginning of the course certain theories that have proved useful in clinical anthropology are presented. Each is illustrated by studying one or more groups living in the greater Southwest, and the method by which the anthropologist obtained and analyzed the data is also presented. The models that are used are (1) a medical system, (2) biological and cultural response to ecology, and (3) healing as an aspect of religion.

Little time is spent on the equally important models from law and economics, since there are other courses available that concentrate on the contributions of those disciplines to the anthropology of health and

illness. More time is devoted to the differences among the concepts of race, culture, ethnic identity, life-style, and social class. These anthropological categories are often misused in studies of disease distribution and in epidemiology. Advanced anthropology students are assigned *Ethnic Identity in the Southwest* by Spicer (1972). For students in the health care fields, the lectures covering these concepts are usually sufficient; if they are not, ethnology courses such as "Indians of the Southwest," "Peoples of Mexico," and "Mexican-American Culture" are recommended as well as introductory courses in physical anthropology.

The history and geography of the greater Southwest are surveyed, because an historical experience, real or in myth, contributes to an identity system. Also, roots in the land may be an important element in this history.

Ethnographic maps that locate the following Southwestern people are distributed to class members: Navajo, western and eastern Apache, Havasupai, Hualapi, Yavapi, Pima, Papago, eastern and western Pueblo, Yaqui, and Yuman linguistic groups. The exploration of these areas, the establishment of missions, and the settlement of these lands by Spanish, English, Chinese, Mormons, blacks, and others are briefly reviewed in lectures.

The concept of system (Malinowski's institution) is then introduced. It is described as an organization of elements, factors, or parts. The most fundamental property of a system is the interdependence of its parts or variables. This interdependence is shown in the relationships among the parts, and in the order among the components that enter into a system. This approach is, of course, structural-functional.

Medical system model

From the concept of system, we proceed to the idea of a medical system, using the definitions by writers such as Clark (1970) and Weaver (1970). Weaver states that a medical system in its entirety includes "the whole complex of a people's beliefs, attitudes, practices, and roles associated with concepts of health and disease, and with patterns of diagnosis and treatment" (p. 141). Thus the components of a health care system model are ideas, roles, and materials. Each of these elements will be discussed.

The principal message of medical anthropology has been that medical culture patterns are not isolated, but rather integrated into a complex network of beliefs and values that are part of the culture of each society. Each health care system is based on a philosophy of what constitutes health and what constitutes illness. It is the group's theory of medicine. This theory consists of propositions formulated from the group's answers to such questions as: "What is illness?" "What causes illness?" "How may illness be prevented?" "How may illness be treated?" The sources of this theory are beliefs about causation.

Another element in a medical system is social role. What kinds of people are needed to do the different tasks of health and healing? And how do societies select people for these roles in a health system? Are individuals found suitable to occupy a specific status because of their achievements, because they have had certain training and a certain initiation such as graduation, or are they given their status by a supernatural power? Is the role inherited, or revealed in a wish or dream? What is the comparative hierarchy of diagnostician, curer, therapist, and care giver?

The third component of a medical system is material. What kinds of equipment are required to make diagnoses and to give treatment? Some of the same materials are used by all systems. For example, many believe that body parts or excreta are extensions of an individual. Thus such remainders are used for diagnostic or therapeutic or witchcraft purposes in every system. Other materials are medicines to swallow, to rub in, to fix on, to irrigate with, or to anoint with.

The Southwest, like other regions, has many medical systems that exist either parallel with or alternative to the official medical system. To illustrate different kinds of medical systems, students in the class are assigned to read Scott's (1974) "Health and Healing Practices Among Five Ethnic Groups in Miami, Florida," which appears on pp. 61 to 70 of this text. These five ethnic groups are Bahamian, Cuban, Haitian, Puerto Rican, and southern U.S. black. Maps from the National Geographic Society and discus-

sion of social stratification further clarify Scott's material.

For a required text we use *Ethnic Medicine in the Southwest* (Spicer, 1977), which details the health culture of urban blacks, Mexican-Americans, Yaquis (Mexican migrant Indians), and lower income Anglos. Some of the material is summarized in Snow's (1974) "Folk Medical Beliefs and Their Implications For Care of Patients," which is assigned for discussion. Stafford in Chapter 2 discusses an example of a patient's simultaneous use of several parallel medical systems. This will also be used in the future. As a principal text, we have used the book edited by Lynch (1966), *The Cross Cultural Approach to Health Behavior*, since it includes so many of the classic articles in medical anthropology that deal with people of the greater Southwest.

Culture, Disease and Healing, edited by Landy (1977), contains excellent readings for students with advanced knowledge in anthropology. One book of readings especially addressed to nurses is Brink's (1976) *Transcultural Nursing*. Branch and Paxton (1976) have compiled *Safe Nursing Care for Ethnic People of Color*. This last text reflects these authors' concern that the entire nursing curriculum should integrate knowledge about groups defined as ethnic people of color, that is, American Indians, Blacks, Chicanos, and Orientals. All of these books contain valuable essays from cultural and physical anthropology.

After the medical system model of clinical anthropology is outlined, the class is introduced to concepts of the epidemiology of disease, defined in terms of the culture of Western scientific medicine. The distinction between disease and illness is clearly explained by Fabrega (1975). Now the health professionals are on more comfortable ground, and the anthropologists less secure. The works of Alexander Alland, for example, *Adaptation in Cultural Evolution: An Approach to Medical Anthropology* (1970), are recommended to those students with a limited background in medicine and parasitology. Hughes' (1961) paper, "Public Health in Non-Literate Societies," presents a model for the influences of life-style and culture on health. Collections such as Rabin et al. (1972), *Health Problems of U.S. and North American Indian Populations*, articles found in the *Index Medicus*, the *Social Sciences Index*, and computer retrieval systems help the students to ferret out medical research relevant to clinical anthropology.

Ecology model

The second principal model in clinical anthropology is ecology. Ecology is given three definitions: biological (that branch of biology that deals with the relations of organisms and their environment), social (the relations of people and institutions and their interdependence), and cultural (the relation of culture and environment, which includes the other cultures and societies that are in the environment). The Navajo are used to illustrate ecology because they have been studied extensively from all three standpoints. Assignments are made from the Lynch reader as well as a newer summary in *Science* (McDermott and coworkers, 1972).

Ecological determinants of disease distribution are demonstrated not only by the Navajo, but also the Apache and Papago peoples. Guest anthropologists illustrate their lectures with slides of the desert, its life forms, and the life-styles that developed in response to the ecological system. One guest lecturer speaks to the class specifically about the work of a clinical anthropologist in the Indian Health Service.

Indian patients are challenging to health care workers at local hospitals. Communication, both verbal and nonverbal, is a principal difficulty. Sections in *The People's Health* (Adair and Deuschle, 1970), a summary of the Cornell project for the Navajo not included in the Lynch reader, are particularly helpful in suggesting some of the linguistic sources of difficulty. The writings of Hall (1959, 1969) are useful for conveying those aspects of nonverbal communication that particularly affect patient care. Kay's (1977) *Southwestern Medical Dictionary* illustrates the differences among scientific, lay, and folk vocabularies.

The geography and history of the Navajo are presented in lecture and further illustrated by a film, "The Navajo Way."* Some Navajos object to this film, which makes it

*This CBS documentary may be obtained from Navajo Community College, Tsaile Az 86556.

useful for stimulating a classroom discussion of the problems of stereotype and the use of old people as principal informants. The film also evokes argument about the role of culture in definitions of problems, suggested by the film's depiction of Navajo drinking. Some students insist that alcoholism is a problem to the white man, not to the drinking Navajo. Others point to Navajo membership in the Native American Church, which forbids alcohol, to show that Navajo do see alcohol as a problem.

Religious model

Traditional Navajo medicine is an aspect of religion. Disease is explained as the result of imbalance between the individual and the total physical and social environment. In this system, the Navajo find no significant distinction between mind and body.

If health and illness come from God, as many people believe, then religion is an important part of the anthropology of health. However, one person's religion is another's magic, witchcraft, or superstition. Traditionally a fascination of anthropologists and folklorists, the study of religion, magic, and witchcraft is difficult for health professionals to see as directly relevant to their practice. It is equally difficult for them to realize that for some groups religion is an equivalent of science. We start the course by reading Miner's (1956) classic, "Body Ritual of the Nacerima," returning periodically to discuss various procedures and therapies of the health professions that appear to be more magical than scientific.

There are several good ethnographic films to illustrate religion as a model for clinical anthropology. I have used "The Holy Ghost People," a film about southern white American Pentecostalists, and "Dream Dances of the Kashia Pomo," both of which may be rented from the Extension Media of the University of California at Berkeley. The University of Arizona purchased "We Believe in the Niño Fidencio." This film is about the cult that has grown around a charismatic healer who lived in Zacatecas, Mexico, in the early part of this century. The film shows a pilgrimage to the place where the Niño lived and cured.

There are several opportunities for clinical anthropology students to observe and perhaps participate in religious ceremonies of health. The feast of St. Francis Xavier is celebrated on October 4 at Magdalena del Kino, site of a mission established by Father Kino at the end of the 17th century. Magdalena is 60 miles south of the border, or 120 miles from Tucson. Festivities extend through the weekend that is nearest to this date. People go to the feast of St. Francis seeking recovery from illness or to petition for continued health and good luck. Papago, Yaqui, and Mexican-Americans go from the United States, celebrating the festival in quite different ways. Mexican people from as far away as Yucatan may come to fulfill a vow by dancing and making music. All can buy herbs or amulets, and join the throng waiting to kiss the statue of St. Francis.

Clinical anthropology students who cannot make the trip to Mexico may see abbreviated versions of the same celebration at the nearby Mission of San Xavier del Bac. In the spring, they may observe the Lenten cycle of dances of the Yaqui, whose dancers have generally joined their societies in gratitude for a cure. Students have gone on invitation to participate in Sufi, Kundalini Yoga, Christian Science, and laying-on-of-hands by members of various cults.

Medical decision-making model

Two other models are discussed. One is medical decision making. I argue the validity of the concept of the culture of poverty, since it has been a popular, if mindless, explanation for why poor people do not go to the doctor. Alternative possibilities are also discussed, such as the theories of structural or behavioral integration, illustrated by the use of family planning agencies. The various reasons individuals do or do not want to have a child are explored, as is these individuals' cultural knowledge of fertility regulation.

Folklore model

Folklore was long ago the dominant model for medical anthropology. Fraser's (1890) and Sumner's (1906) monumental works are known today only by scholars of literature and a few psychoanalysts. I try to present folklore as a scientific model for clinical anthropology, teaching it by readings and field method instruction when there is interest.

Careful recording and filing of materials are demonstrated. The use of the camera and the tape recorder for data collection is encouraged. Class members discuss technical problems associated with these methods. I demonstrate collecting, preserving, and mounting botanical specimens of medicinal herbs and indicate available sources for botanical identification.

STUDENT RESEARCH

The main way that students begin to learn clinical anthropology is through their own research. Each student selects a problem based on his or her interest. For a surprising number of students, this is a first experience in field work. A few others have already done field work but lack a frame of reference either in anthropology or in health care for selecting data to use and analyze.

Selection of a problem that is small enough to investigate during one semester is the first task. Clinical anthropology is not reductionist but holistic. Which of the various possible determinants of health behavior should be covered? Which method of data collection is most appropriate for the problem? Reading assignments are made in textbooks of field methods such as Brownlee's (1978) *Community, Culture, and Care* and Crane and Angrossino's (1974) *Field Projects in Anthropology.*

The population studied may be one of the groups already identified, such as Mexican-American, Navajo, or Anglo. Any group to which the student has access is used. Thus students have written papers on the medical systems of Greek-Americans, Vietnamese refugees, Cubans, urban black migrants, American blacks, Mormons, Pentecostalists, Chinese-Americans, Christian Scientists, middle class Anglos, and neo-Orientals (for example Zen Macrobiotic). Some students may use the opportunity of the project to discover ethnic roots.

These beginning students face the problems of all field workers. Should ethnographies of the people to be studied be read prior to starting their research? If field workers do not read first, they may merely rediscover the same elements that have already been found and described. On the other hand, too much time in the library may so prejudice their observations that the students are oblivious to cultural or social change. Field workers who already know what they will see might as well stay home.

Selection of informants is the next problem. Do aged women who remember old healing practices or young people enculturated to the medical system of the dominant society make the best representatives of a medical culture? To what extent is a particular aspect of a culture shared? Students may find wide discrepancies among their few informants, and this diversity may cause them to question the validity of anthropological technique or even to reject the concept of culture. How does one know that the total variation in a society will be represented from only a few informants? Indeed, the problems of diversity plague many anthropologists, and these are serious problems in applied anthropology.

A related problem is that of stereotype. Anthropology looks at patterns, standards, or norms. Students who have only a superficial acquaintance with the anthropology that comes from popular literature or only a brief academic introduction followed by cursory research may come to conclusions such as "Navajos do not believe in germs"; "Blacks will not accept surgery"; "All Mexicans prefer herbs to synthetic medicines"; and so on. I believe that the seminar design of the class, with forthright challenges of ideas may lessen the tendency to stereotype since the utility of the concept of culture is not rejected.

Students must then get permission to do their research, both from their informants and from the committee to protect human subjects. Our students are required to submit their protocols to the College of Nursing Ethical Review Committee, which judges if subjects are at psychological, social, or biological risk. The College of Nursing committee then passes the protocol and their recommendations to the University committee. This is an excellent exercise for the student, as well as a way to prevent abuse of research. It provides an opportunity to discuss in class the implications of "informed consent," what is meant by risk, and other ethical issues. It is also very time consuming for the faculty. At present, the interpretation of the Privacy Act (1974) by some institutions is making it harder and harder to get permission to do research that otherwise appears to offer no