THE CULTURAL CONTEXT OF HEALTH, ILLNESS, AND MEDICINE

Elisa J. Sobo and Martha O. Loustaunau

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Second Edition

Elisa J. Sobo and Martha O. Loustaunau

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Preface to Second Edition

People of all cultures confront illness, disability, and death: everyone gets sick, many become disabled, and ultimately everyone dies. Systems of health care thus exist within every culture, as a **cultural universal**. The ways in which we perceive and interpret health and illness, and seek and deliver care, however, are inextricably bound up with cultural norms, beliefs, and values, as well as by social structure and environmental conditions. This book focuses on the various dimensions of this relationship, as did its first edition.

However, times have changed. When the first edition was written, the cultural competence movement had not yet emerged. Today, it is well-established. Yet the need for change persists. The new edition continues to press for positive modifications, but it also now urges a more sophisticated approach: Culture is a far more multifaceted human process than "recipe" or checklist models allow.

Moreover, political, economic, and sociocultural contexts have shifted, as have the ways that we handle health, illness, medicine, and health care delivery. For example, cultural ideas regarding complementary and alternative medicine, genetic testing, use of technology for medical communication, and even the value of being a multicultural society have evolved. Health challenges themselves have evolved, both for better (for instance with new drug discoveries, such as for treatment of HIV/AIDS) and for worse (with emerging infectious diseases, increasing health disparities, etc.). The second edition of this

text reflects such changes, and includes updates on concepts, theories, and research and development. As a result, the systems perspective has been strengthened. As well, greater appreciation of cultural evolution's role in health care's evolution is promoted. Several new sections also have been added, incorporating relevant new information, including on globalization, stress, health care consumerism, reform, and technology. The discussion questions at each chapter's end have, accordingly, been updated.

Throughout the revision process, our goal has mainly been to keep the text relevant, and so where newer scholarship simply corroborated older observations, especially those now considered seminal, the text remains as it was. Older references retained therefore do not index a dated text; rather, they reveal to readers the historical depth of certain patterns or ideas.

Continuity also is maintained in the way that the book continues to promote the transdisciplinary perspective that brought us together in the early 1990s when we realized the need for a text examining the multicultural context of health, illness, and medicine from a combined sociological and anthropological standpoint. Separate disciplines are often too narrow in their focus and interpretations; the use of transdisciplinary viewpoints offers a broader, more illuminating perspective. The subdisciplines of medical sociology and medical anthropology address health, illness, and medicine from very similar, sometimes overlapping, and yet often distinctive perspectives. Although there has been much cross-disciplinary fertilization and borrowing, each discipline has its specific focus and terminology. This text draws on the strengths of each discipline.

Although, in the interest of space, with the second as with the first edition we have had to streamline the bibliography and be selective regarding topics covered and level of detail, we still include ideas and research from numerous perspectives within our respective disciplines, and discussions on current (often controversial) issues. Our purpose is still to generate in readers the motivation and capability to recognize and understand socially and culturally relevant factors that influence our views and constructions of health, illness, and healing, as well as of science and medicine.

Given this goal, from the start our project was not one that we could carry out on our own. While we, alone, are responsible for this work, shortcomings and all, we are indebted to colleagues for their insightful and critical comments and suggestions, and for kindly permitting us to quote from their works. Although we do not have the space to name all

who contributed, those to whom we owe thanks, beginning with the first edition, include Helen Ball, Robert Echenberg, S. Malia Fullerton, Geri-Ann Galanti, H. Jack Geiger, Kate Hill, Pat Hippo, Jill Kerr, Tamara Kohn, Terry Meyer, Mark Nathan, Milagros Pena, Billy Reeves, Andrew Russell, Charles Sanders, Robert Simpson, Loudell Snow, Adina Sobo, and Wenda Trevathan, not to mention our long-suffering spouses, Joaquin Loustaunau and Harvey Smallman, who sweated through the project with us. For the second edition, we give special thanks to educators, students, and health professionals who embraced the first edition and advocated the present update.

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Introduction

This book brings together medical sociology and medical anthropology in an effort to provide a useful resource for developing and delivering relevant and effective health care. Long traditions of research on medically related topics exist in both anthropology and sociology. But the formal subdisciplines of medical sociology and medical anthropology began to emerge as such only in the mid-1900s. This introduction reviews their emergence and then outlines a chapter-by-chapter road map for the journey we intend to take using insights from each of these subfields.

A BRIEF DISCIPLINARY HISTORY

Medical Anthropology

Medical anthropology did not stand out from general anthropology until well after World War II, when it received impetus and support from applied work in the arena of international public health, much of which was government funded. Many saw the field in the 1960s as a "practice discipline" (Good 1994), dedicated to the service of improving public health in economically poor nations.

Despite the fact that this recent involvement with public health was key to its formal emergence, medical anthropology has old roots. These extend in two general directions, reflecting two kinds of

anthropology: biological or what used to be called "physical," and sociocultural. And while some anthropologists from both camps followed the public health line when it came along, others kept their interests academic.

Indeed, there was great debate within the discipline regarding the merits of either angle, with many asserting that applied work was inferior or somehow tainted anthropology's academic dignity. Even George Foster, a key founding figure in U.S. medical anthropology, had to work through ambivalences here. "We were trained to despise applied anthropology," he once said, recalling that he did not join the Society for Applied Anthropology until 1950; until then "I would have nothing of it" (Foster 2000, quoted in Kemper 2006). Today, however, that divide has been recognized as wrong-headed. Theory can really be tested only when applied, and good applied work hinges on a strong theoretical grounding.

Most medical anthropologists take somewhat of a systems approach in their work in any case. Among biological medical anthropologists, major areas of study include diet, nutrition, and evolutionary adaptation. In the sociocultural branch of anthropology, which is the branch this book draws most upon, there has been a long-standing ethnographic interest in medical practices, knowledge, and beliefs, generally viewed as part of the total culture of peoples studied (Foster 1978; for more on early history, see also Sobo in press).

In the later part of the twentieth century, however, many socioculturally oriented anthropologists turned toward symbolic analysis of illness representations and explanations, in both medical knowledge and popular social representations of the body and of diseases, such as AIDS. A trend toward strengthening worn ties between the biological and sociocultural branches of anthropology also took root. Of late, interest in human-environment interaction has increased, in tandem with a boost in popular interest in a "greener" lifestyle.

Also today, persons' socioculturally situated "subjectivities" or inner lives and experiences are attracting attention, as are issues related to global flows, for instance of technologies, medicines—and even patients. The critical perspective, which takes global and local political and economic arrangements into account, has come to be an expected aspect of medical anthropological work. Indeed, social variables have been increasingly factored in as the links between sociology and anthropology have been strengthened (e.g., Auge and Herzlich 1995). Medical anthropology, however, has only recently entered into medical school curricula on a wide scale, and more often than not this

is in the problematic arena of "cultural competence" (more of which later; see Chapter 7).

Medical Sociology

Medical sociology's history is quite different. Reflecting positivist values, the subdiscipline was situated within the framework of the scientific medical model from the start; it saw medicine as part of a functioning social system, and illness as a form of deviance (e.g., Parsons 1951). Changes in morbidity and mortality after World War II, the rise of preventive medicine, the establishment of modern psychiatry, and administrative needs contributed to medical sociology's rise (Coe 1978). Medical sociologists gained acceptance and credibility through applied work from within the medical field, finding faculty positions in medical schools. There was, however, little or no recognition that "medicine" includes diverse systems, all of which are influenced by the cultural contexts in which they are actualized (Gerhardt 1989).

In addition to applied sociology within the medical field, sociological interests essentially cover four broad categories: the relationship between environment and health and illness; health and illness behaviors; the relationship of health care practitioners with their patients; and the health care system or the organization of health care delivery (Weiss and Lonnquist, 1994, 6). Further, the concept of culture has become more significant in medical sociology. Like anthropologists, many sociologists now consider biomedicine both a product of culture and a culture in itself.

While sociologists still focus on the dominant medical systems in both Europe and America, since the early 1980s medical sociology has expanded and broadened in scope, becoming an academic discipline with a focus on practical application. As noted by Cockerham, "Not only have the numbers of medical sociologists continually increased, but also the scope of matters pertinent to medical sociology has clearly broadened as issues of health, illness, and medicine have become a medium through which general issues and concerns about society have been expressed" (2010, 7). Both the sociological and medical fields have recognized that they have mutual interests that converge. Medical sociologists of the twenty-first century are most concerned with how the discipline increases our knowledge and understanding of the "complex relationship between social factors and health" (7).

A CHOICE OF TERMS

Much research in medical sociology and anthropology originates from within the perspective of European and American scientifically and, particularly, biologically (and, increasingly, genetically) based medicine. This system is generally referred to as the "true" or benchmark medical system. In comparison, other medical systems, from Chinese acupuncture to Caribbean bush medicine, are often dismissed and devalued without consideration or understanding of possible functions or benefits. The dominant medical system often is referred to by such terms as "modern medicine," "cosmopolitan medicine," "Western medicine," "clinical medicine," "mainstream medicine," and "biomedicine." Each term has its pros and cons.

In this text, we have chosen to use the term "biomedicine" when discussing the dominant medical system, since "bio" suggests that health and wellness are physiological issues, which are the focus of the biomedical model. We do note that other medicines may also be biologically grounded (albeit perhaps in biologies that differ from the dominant U.S. or European version). We will refer to our subdisciplines as "medical," because professional associations in the United States use the label, and with the understanding that the subjects covered go far beyond the generic term of identification.

"Science" is a term that can also be problematic. Many systems claim "scientific" systematized knowledge derived from observation and study. However, our use of "science" in relation to medicine refers to the series of systematic, organized steps that ensures maximum objectivity as well as consistency in research. This system, known as the scientific method, has produced discoveries and inventions from antibiotics and surgical success to genetic engineering and space travel. It is not, of course, value free: Recent investigations have called into question the objectivity of the research process, the nature of evidentiary claims, and so on (see, for instance, Lambert 2006; Lipman 2000; Sobo 2009; see also Lambert, Gordon, and Bogdan-Lovis 2006).

Another terminological problem with which we have had to come to grips involves the national focus of the text. While it is true that much of what we say has implications for other economically developed nations, including most Western European nations, most of the research we cite in relation to biomedicine is written from a U.S. perspective. So, the generalizations that can be made from this work

notwithstanding, when we refer to "our" society, we are referring to the United States. We use the term "America" to refer to the United States advisedly: America really is the name of a continent group, and there are many nations in the Americas.

One last problem with terminology involves the distinctions among the definitions of "illness," "sickness," and "disease." While "disease" refers to the medical or pathological source of a problem, "illness" generally refers to the individual experience of being ill.

Sociologists use the word "sickness" for describing a social response to unwellness as a form of deviance. Unwellness requires a person to take on, at least temporarily, a social role, referring to societal expectations about the attitudes and behavior of the "sick" person. In anthropological jargon, the term "sickness" can be used to draw attention to the social-structural causes of unwellness.

Notwithstanding such technical distinctions (and regarding their history, see Parsons 1951; Cockerham 2010, 158), illness and sickness are often used interchangeably. We have attempted to use them appropriately, but recognize that meanings may become blurred and have therefore often used the term "illness" as a general designation.

THE *SOCIOCULTURAL* APPROACH: A CHOICE BLEND

One of medical anthropology's founders, George Foster, in his discussion of the disciplines of sociology and anthropology, noted the value of combining them in order to learn more by providing a broader perspective: "Precisely because we ask different questions, seek out different data, and come to conclusions that reflect our professional biases, our total understanding of medical and health phenomena is richer and more varied than if the task were left to a single discipline. We are in complementary, and not competitive, lines of work. We learn from each other, and we teach each other. Our society needs both of us" (1978, 10–11). As a sociologist (Loustaunau) and an anthropologist (Sobo), we agree.

The basic focus of this text is therefore to examine the role of cultural differences in defining and dealing with health and illness, and to investigate the health-related factors that link humanity cross-culturally through common needs, using our two related disciplines. Each perspective gives us specific knowledge and understanding of the many elements that make up health, illness, and medical behaviors

and systems. Both perspectives recognize how an appreciation for and an understanding of cultural diversity as well as commonalities are essential for developing a unified and effective system of health care delivery in our distinctly multicultural nation. And, in doing so, neither perspective will let slip from view the social-structural factors that contribute to health inequities, whether locally or globally.

Health care in the United States is based upon the biomedical model (defined earlier). Until recently, the biomedical model has not supported cultural awareness and sensitivity in health care delivery, whether for acute problems, for chronic conditions, or in recovery or rehabilitation. It has also, until recently, given little recognition to alternative healing systems and beliefs that exist side by side with biomedicine and that are often used instead of or in conjunction with mainstream care.

At the same time, America has grown increasingly culturally diverse. Drawing from both sociology and anthropology, we examine how cultural backgrounds, diverse beliefs and values, and societal structures are related to physical and mental health. What are the various ways people perceive health and illness, and how do those perceptions affect related behaviors? What political and economic issues are involved? How and why does the health system that is meant to care for all of us incorporate or exclude those cultural aspects of our identities that play such a large part in our health status? How can we improve this system's ability to provide the best possible quality of life for those it serves? And why does culture matter?

THE TEXT: A PREVIEW

In Chapter 1, we examine the concept of culture, and establish its significance with relation to health and illness. The role of culture is explored in terms of identity and behavior, and its consequent links to health, disease, and illness.

Issues of ethnocentrism, cultural relativism, and multiculturalism are addressed in relation to social and political controversy, and the difficulties of finding a balance between diversity and unity are explored. We suggest that medical care that excludes diverse cultural factors and considerations falls short of addressing human needs that must be met.

Chapter 2 explores the influence of social structure and related variables in causes of and approaches to health and illness in our

multicultural society. The pivotal roles of kinship and family, ethnicity, gender, and social class are shown to shape how both consumers and providers perceive and deal with illness and maintain health. These variables are also examined as sources for and causes of illness, and of discrimination in and barriers to care seeking and treatment—some of which support persisting health inequities.

The different stages of our lives entail different health and illness challenges and require different approaches to care and coping. Chapter 3 addresses birth and childhood, adolescence, adulthood, and old age; it investigates the many and diverse cultural issues associated with these life stages. Issues of sexuality, maternal-child health, and death are also discussed in relation to cultural context, focusing on their implications for health care on the personal and structural levels.

All cultures have socially sanctioned as well as limited, marginalized, quasi, and auxiliary modalities of treatment. Chapter 4 defines and discusses a number of these modalities. It includes an examination of intercultural differences and commonalities, and of ways in which many of these modalities may be complementary. Dangerous therapies and quackery are also discussed as they relate to cultural relativity, individual choice, and legal concerns. We stress the need for education of both providers and consumers.

Chapters 5 and 6 examine how the U.S. health care system evolved from its diverse folk roots into the now dominant biomedical culture. Various cultural contributions and institutional values, as well as technological developments and the emergence of powerful political and economic interests, have all played roles in the formation of the American health care system and the resulting dominance of biomedicine in it.

Biomedicine is characterized both as a part of the larger culture, reflecting its mainstream norms, values, and beliefs, and as a culture in itself, based on the scientific model, with its own language, structure, and, again, norms, values, and beliefs. Biomedical culture also is viewed in terms of various elements, including service versus profit orientations in care delivery, changing patient- or client-practitioner relationships, ethical concerns as they are fueled by increasing costs and new technological and service innovations, pressures for (and against) reform, and globalization processes. All reveal the limitations of the biomedical paradigm.

Chapter 7 centers on problems of cross-cultural communication. Besides language differences, ethnocentrism too must be overcome.

This chapter discusses cultural sensitivity, using examples, and describes various techniques by which health care workers can more effectively serve culturally diverse populations.

We tie the lessons of previous chapters together in Chapter 8, which discusses, by way of example, the connections between culture and HIV/AIDS. We focus particularly on HIV because cultural attitudes, perceptions, beliefs, and norms are so very important in the transmission, prevention, and treatment of such health threats. However, the lessons can be generalized or extended to most other health challenges. Recent treatment of so-called swine flu exemplifies this.

Chapter 8 also suggests how the various modalities and themes addressed throughout the text might be combined and integrated to provide more sensitive, effective, humane, and accessible health care overall. The need for cooperation and inclusion rather than narrowly focused and competitive models is stressed. Issues of cost, power, relativism and diversity, communication, and respect for human rights must be considered with the aim of moving toward a more realistic model of health care delivery in increasingly pluralistic contexts.

GOALS AND CONSIDERATIONS

This book was not written to answer all of the very difficult questions raised by the challenging problems of health care delivery in a multicultural society. It does, however, emphasize the links that have been identified between culture, social structure, and the health and well-being of a population. What those links are, and their role in the evolution and provision of just and humane health care, is a main focus of this volume. Increasing cultural diversity, burgeoning technology, health care disparities, and global health issues are forcing change in the system in spite of economic and political resistance.

Beyond sharing with readers background information on this context and the ways it affects and is implicated in biomedicine, we ask how to retain and utilize knowledge of cultural diversity in biomedical care delivery while maintaining a sense of unity in the face of common difficulties of suffering across cultures. Inclusion of an understanding and appreciation of cultural diversity and commonality in the education of health care providers, as well as of patients, is vital and essential for creating an effective health care system.

CHAPTER 1

The Concept of Culture

GOAL: Explain and analyze the concept of culture and identify its components and elements through anthropological and sociological approaches.

GOAL: Examine ethnocentrism, cultural relativism, and multiculturalism and become aware of their meanings, controversies, impacts, and significance for health care in the twenty-first century.

If anything was made to be taken for granted, it is culture.

(Gallagher and Subedi 1995, 4)

Culture is present in all aspects of life. And yet, until faced with a contrasting culture that challenges the basis of our beliefs, values, and identity, we generally take our own culture for granted. In the area of health care provision, cultural diversity and the experience of contrasts is increasing. This affects the relationships of patients and providers and the outcomes of their interactions, as well as the relationships between and among providers themselves. Effective and humane health care demands that we all learn more about culture—what it is, how it functions, and its relevance for our interactions and their outcomes.

WHAT IS CULTURE?

In attempting to understand and analyze health and illness in any society, individual behaviors, interactions, and social structures must be placed within a cultural context. A **culture** is, put briefly, a society's shared, learned knowledge base and behavior patterns. A **society** consists of people who interact together, guided by their culture.

Societies have organizational or **social structures**, by which various roles, statuses, and systems such as marriage, education, and work are arranged in patterns of relationships to each other and passed down through generations. Social structures are more, or less, hierarchical depending on the cultures that support them. Importantly, social structures do not stand alone: Today more than ever, societies are linked together in a complex global system (see Chapter 2).

Culture guides how people live, what they generally believe and value, how they communicate, and what are their habits, customs, and tastes. It guides the ways people meet the various needs of society: how goods and services are produced and distributed; how power and decision making are designated, what god or gods are represented (if any). Culture prescribes rituals, art forms, entertainment, and customs of daily living. Most certainly, the ways in which we interpret and perceive health and illness and our choices in providing and seeking care are influenced by our culture.

Culture is in some ways then a kind of knowledge base that we use and act on. Some of this knowledge is **declarative** in that it consists of apparently factual information ("Mint tea is good for digestion"). Some of it is **procedural**, or how-to information ("Boil a handful of mint leaves in water until the water turns dark; pour this water into a cup through a strainer and drink when cool enough"). Cultural knowledge of both kinds exists in relation to all realms of existence, including subsistence or food production, economics, kinship, government or the maintenance of order, religion, gender, leisure, and health and illness. Importantly, cultural knowledge can be changed or adapted by its users to fit new conditions. A group's culture is always evolving as the life circumstances of the group change (see Wedenoja and Sobo 1997).

Cultures are composed of norms, values, and beliefs. These are the rules of the game—the guidelines for action. **Norms** set standards for appropriate behavior. These standards are based on cultural **values**, or principles by which members of a culture determine what

is right and wrong, good and bad. **Beliefs** are what a culture deems to be true or false.

Norms, values, and beliefs are made real through action, in word and deed. Members of a culture generally strive to enforce cultural norms, either informally, or formally through law. When norms are violated, cultural punishments may be invoked, by the individual who judges his or her own behavior self-reflexively, by his or her community, or by both. Depending on the nature of the violation, punishment may entail anything from light scorn to execution (whether self-imposed, as suicide, or imposed by others). In addition to varying across cultures, norms, values, and beliefs also vary over time. Importantly, cultural evolution is due not only to outside forces but to the ongoing negotiations by its members.

Dominant Cultures and Subcultures

The United States is considered a **pluralistic** society in which multiple cultures ideally exist side by side in harmony. Basic institutions are also shared by all, including the political, economic, and legal systems as well as a common language. Pluralism as an ideal, however, is greatly endangered by prejudice, discrimination, and selective immigration policies. Pluralism is also qualified. Where multiple cultures mix or meet, as they do in the United States, the society must promote some sense of consensus among all members concerning basic norms, beliefs, and values. The mainstream or **dominant culture** (sometimes referred to as a **core** culture) is the one whose norms, values, language, structures, and institutions tend to predominate.

In the United States, the dominant culture has typically been white due to colonization by peoples of Western European origins. Williams (1970) identified 15 of what he considered to be major themes and value orientations representative of the dominant culture in the United States—orientations still relevant today, for the most part.

1. Personal achievement and success
2. Hard work and productivity
3. Humanitarianism and support of the "underdog"
4. Orientation toward moral judgments of events and situations
5. Pragmatism, or practicality and efficiency

6. Progress toward a better life
7. Materialism and consumerism
8. Equality for all
9. Freedom and individual autonomy
10. Outward conformity, as in dress, recreation, housing, and political expression
11. Science as a tool of mastery over the environment
12. Nationalism and loyalty to that which is "American"
13. Democratic principles and belief in everyone having a voice in political matters
14. Individual importance and responsibility
15. Racism and the idea of group superiority

Some of those themes indicate conflicting values, such as the value of equality (the idea that all people have a right to health care) and an emphasis on racism and related group superiority (which results in denial of care to those without insurance or who cannot pay—generally members of various disadvantaged racial and ethnic groups and most recently undocumented immigrants).

Contradictions like these are common in all cultures. Cultural changes, such as those produced by the civil rights movement of the 1960s, or the recently popularized push to decrease our carbon footprint, eat sustainable foods, and otherwise "go green," often come about in the ongoing attempt to resolve the contradictions in core orientations. Such changes may bring about new contradictions, and even produce a backlash.

Another result may be the formation of deviant or **countercultures**; these entail alternative lifestyles for those who cannot conform to or actively oppose widely accepted social norms. Because biomedicine is a part of the dominant culture in the United States, those alternative medical movements that reject the biomedical approach, such as Christian Science, exist, at least in terms of medical systems, as countercultures.

While countercultures emerge in opposition to the dominant culture, a **subculture** is generally considered a group within a larger group: a subgroup (meaning a subset, with no implication of inferiority) that lives within the general norms of a dominant group while preserving, to an extent, a unique lifestyle. The differences between cultures and subcultures may be based on political affiliations, socialization

experiences, language, ethnicity, age, religion, occupation, health status such as disability, class, gender, and so on.

The various health care professions, for instance, form subcultures. When a person decides to become a doctor, for example, he or she will learn not only a new vocabulary, but also a new way of seeing that goes with that vocabulary. As a Harvard medical student explains, "In a sense we are learning a whole new world. . . . because learning new names for things is to learn new things about them. If you know the name of every tree you look at trees differently. Otherwise they're just trees" (Good and Good 1993, 98).

Regarding patients, another student said, " 'At first you are very aware that you are dealing with another person. Now I just don't think about that any more. You just do the routine' " (Good and Good 1993, 101). Added another, " 'I've had some real perception changes of people. . . . More and more, I can't help but think of us as machines' " (96). Becoming a doctor—or an acupuncturist, or nurse, or *Vodun* (sometimes spelled Voodoo) priestess, or any kind of health worker—is a process of acculturation as much as the result of long hours of hard work and study.

Subcultural groups and their members may be **bicultural**, functioning equally within their traditional milieu and the dominant culture; they also may hold to their own traditions while rejecting many of the dominant ones. Various groups may have become **acculturated**, having given up most of the traits of their original cultures and adopted those of the dominant group to a greater degree in some areas than in others. For example, they may reject the biomedical explanation of disease and its modes of treatment while fully accepting the dietary habits and patterns of dress of the dominant culture.

The United States is full of acculturating—and acculturated—people. However, **enculturation** (cultural socialization from birth) is such a powerful process that health crises often lead even the most highly acculturated people to return to their original cultural patterns. Seriously sick or injured people may also return to their native language and require a translator when brought in for care. It is therefore extremely important that the health provider have an appreciation of the various cultures and cultural nuances of the people served.

Is Culture All?

Despite the foregoing, behavior is not determined solely by culture, or any other one factor. A mental framework holding that one force

determines how we think and behave is called **determinism**. Environmental determinism, for instance, posits that we are as we are due to the climate or environment of the geographic area we inhabit. Biological determinism holds that biology or genetic factors are key.

Biological factors surely do play a role in determining some dimensions of human lifeways. Genetic research, for example, is revealing a multiplicity of data regarding various populations' odds for contracting various diseases. However, genetic factors do not act alone to determine outcomes. Gene expression can be influenced by environment, as the emerging field of epigenetics has revealed. For instance, some genes related to obesity are turned on and off by environmental exposures to chemicals (Weinhold 2006). Our environments are, of course, in many ways culturally determined; we are the ones who pollute them. Further, much biological determinism is in actuality thinly disguised racism.

The case of erroneous arguments that IQ (a measure of intelligence) is determined by race is an example of such. Biased findings indicating that whites are intellectually superior to other groups are used to justify white oppression of nonwhites as biologically determined, or natural. But cross-cultural data shows that the intelligence measured by IQ testing is shaped by class and culture, not by race (see Fraser 1995).

This is easily seen in data from a study of children's intelligence published nearly 40 years ago. The study (Cole 1975, as cited in Nunley 1995) tested children's grasp of the idea of conservation, "the idea that when you pour all the water from a short glass into a tall glass, the same amount of water is still present, or if you take a fat ball of clay and roll it into a long narrow string of clay, the same amount of clay is there" (Nunley 1995, 76). The study was carried out with children of potters in Mexico and children in a West African fishing village. When water was used, the fishing village children did better, but when clay was used, they were outscored by the potters' children.

The majority of research shows that racial differences in IQ mask inequalities linked to poverty and limited life chances (Nisbett 2005). Further, differences have little significance in terms of actual intelligence; they measure only a narrow (and culturally determined) type of cognitive achievement (Gross 1992, 222–23).

In the **nature versus nurture** debate, nature, or biology, is pitted against nurture, or culture, as the explanation for the human condition. In reality, neither is true; both positions are too extreme and too simplistic. Real human thought and action is the outcome of a complex interplay of nature and nurture—of cultural, biological, social, psychological, economic, and political variables, all themselves historically

contingent. In part because culture forms the framework within which social, economic, political, and other such changes take place, in anthropology as well as in sociology, culture is key.

ETHNOCENTRICTY, MEDICOCENTRICITY, AND CULTURAL RELATIVISM

Culture Blindness

Culture from either the anthropological or sociological perspective can be seen as a measure of human flexibility. Its study reveals the amazing diversity of ways and means of meeting human needs under all sorts of conditions. Culture is both an abstraction and a blueprint or guide for social analysis as well as something enacted and negotiated. By studying the various elements of culture, we can begin to understand different social groups, the cultural contexts in which they function, and the links between cultural context, healing institutions, and human behavior related to illness and help seeking.

Loudell Snow has studied African American medical practices for many years. Snow describes the case of John and Eva Thompson (pseudonyms). The Thompsons had brought their baby, Patty, to the pediatrics clinic for her first immunization. Snow, affiliated with the clinic in her capacity as an anthropologist, sat in on the consultation (1993, 95).

The doctor administered the shot and then asked if there were any questions, and the parents had none. However, as soon as the doctor had left the room, Mrs. Thompson turned to Snow and asked if she had ever heard of using catnip tea for colic. As Snow tells it, "I replied that I knew it was a popular remedy in the neighborhood—but that I had always wondered how people knew how strong to make it. Mrs. Thompson's response was, 'Why it *says* right on the box!' " Mrs. Thompson also told Snow that adding a bit of honey made the tea taste better to the infant, and she and her husband told Snow a few other things about their medical traditions as well as their medical history—things that the attending physician was never told (1993, 95–96; italics in original).

When Snow shared with the physician the important medical history information that the woman and her husband had provided, she was annoyed. " 'I don't know why these people always tell *you* everything' " (1993, 96; Snow's italics), she said to Snow. "It does seem

obvious," Snow reflects, "that the initial question about catnip tea was a test: Mrs. Thompson clearly knew about catnip tea for colic, exactly how to prepare it, and, in fact, was already using it. Had I responded in a negative fashion she probably would not have gone on" (97). The Thompsons were worried about the possibility of being negatively judged for their practices—of being the victims of ethnocentrism. Their story is two decades old now but remains iconic; and such worries (and strategies) are of course not limited to African Americans. Many have observed similar scenarios (e.g., Prussing et al. 2004).

Ethnocentrism involves using one's own standards, values, and beliefs to make judgments about someone else. The standards against which others are measured are understood to be superior, true, or morally correct, while those being evaluated and not "measuring up" are inferior or wrong. Ethnocentrism can be observed in all types of cultural, social, and even personal evaluations when we condemn the customs, ideas, behavior, values, and beliefs of someone else when they are different from our own.

Ethnocentrism can also be observed regarding the tenets of science and medicine, which as noted may be considered natural or "correct" and therefore outside of cultural considerations. This attitude has been termed **medicocentrism** (Pfifferling 1981, 197). A medicocentric view focuses on disease, identified through signs and symptoms, and not on the patient or the patient's perception of a problem. The medicocentric physician uses a **reductionist** model, trying to make a diagnosis by narrowing (or reducing) the problem to medically explained phenomena (**disease**). But the patient may attempt to expand and relate the problem to his or her own perceptions and experiences, such as inability to carry out daily functions, symptom recognition and interpretation, misfortune, and discomfort (**illness**).

Physicians, as products of their own cultures, as well as of their medical training and occupational subculture, may exhibit both ethnocentric and medicocentric attitudes, which compounds the problem of bias. Let us say, for example, that Ms. Jones, a working-class woman has come to see Dr. Smith, who has confirmed her suspicion that she is pregnant. Dr. Smith also finds that she is malnourished and requires a great deal of prenatal care. Ms. Jones happens to be unmarried. Dr. Smith does not think that unmarried women should have babies. He lectures Ms. Jones on the use of birth control and pointedly mentions the option of tubal ligation (a form of sterilization). He writes a prescription and recommends certain foods and vitamins, as well as time off work and daily walks, without considering that

Ms. Jones cannot afford the food, supplements, and prescriptions, or that she must continue working in order to pay the rent, or that her neighborhood is not conducive to strolls. The probability of her following through on all of his recommendations is extremely low (DiMatteo and DiNicola 1982, Chapter 5).

Cultural Relativism

The concept of **cultural relativism** requires that we objectively consider actions, beliefs, values, and norms within their own cultural contexts in order to understand them. It demands a situated understanding of what people do and because of this it generally clarifies the "why" through an appeal to cultural context. Cultural relativism asks what functions various cultural elements serve within that cultural context and how they are sustained, not whether they are "good" or "bad" by external standards. Cultural elements are deemed not better, not worse, just different.

One example of this is body modification (e.g., tattooing, scarification, penile circumcision) practiced in some cultures in initiating boys into manhood. Different cultures promote different forms of modification (Burton 2001). In cultural context, the modifications mark the body as mature, ensuring certain social rights and obligations to their bearers, and are painful—but not life threatening. Therefore, they may be acceptable within the framework of cultural relativism.

Cultural relativism presents some difficulties, however, when cultural beliefs and practices are harmful or based on cultural biases that in turn cause harm. They may even have legal implications from the perspective of the dominant culture. Furthermore, acts of torture, terrorism, oppression, persecution, poverty, suffering, and disease in any society have repercussions around the globe. In short, cultural relativism does not imply that practices must be accepted; *cultural relativism does not require moral relativism* as well. And yet, when we practice cultural relativism we are sometimes pushed to adopt—or assumed to hold—a morally relativist position as well. Because of this, just where to draw the line in determining whether cultural relativism is a helpful part of the health care process can be a difficult question.

Take, for example, female genital surgery or modification, sometimes referred to as female genital mutilation, or FGM, which is practiced in a number of countries. The hood of the clitoris, the clitoris itself, or the clitoris as well as both the inner and outer labia are

removed. The latter form of the operation, which is most common in the Sudan and Nubian Egypt, is called infibulation: "The two sides of the wound [are] then stitched together, leaving a small pinhole opening for the drop by drop passage of urine and menstrual blood" (Gordon 1991, 5).

The practice of FGM is based on an ideal image of the female body as lacking certain parts of or all external genitalia (as opposed to male bodies, on which external genitalia are expected), and the belief that by removal of these body parts females will not become sexually active or desirous, will remain virgins until marriage, and will be faithful afterward. Moreover, the clitoris is considered as "dirty," and the female is not fit for marriage until it has been removed and she is "clean" (e.g., Gordon 1991, 9). One name for female genital operations is *tahara*, meaning purity. While in cultures that value FGM, females without it are stigmatized and denied most social options, FGM is excruciatingly painful, nontherapeutic, and medically can be very dangerous due to infection and ensuing debilitation.

FGM gained increasing recognition in the early 1990s as globalization brought populations that practice FGM in contact with those that do not. Some immigrant groups have been said to be importing specialists to perform the ritual. Physicians in the United States who have seen the results of FGM have strongly condemned it (e.g., Toubia 1994).

Intercultural contact produces diffusion, adaptation, innovation, and change, hopefully for the better. The human rights position can easily be defended on the basis of the fact that all cultures are in constant flux; that is, even so-called tradition changes and, therefore, traditional practices need not be cast as sacrosanct. Traditions may become outmoded and impractical. But all peoples have certain rights by virtue of being human. Perhaps surprisingly, it was not until relatively recently that this stance was encoded in the International Bill of Human Rights (United Nations 1978).

HUMAN SIMILARITY, HUMAN DIVERSITY: THE MULTICULTURAL SOCIETY

In the past, the United States promoted assimilation, and many of its citizens—old, new, and aspiring—boasted of its status as a great melting pot. Corporations even offered classes to immigrant workers regarding "American" ways of behaving, and some penalized workers who did not assimilate fast or well enough. However, the values and