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**Cross-Cultural Healthcare:**

The Religion of Medicine

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PHIL 2050

21 April 2023

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As modern medicine continues to expand, with perspectives of science changing, cross-cultural medicine plays a critical role in a growing population of diversity. The dissonance between medical efforts and those whose religious or cultural beliefs go against such care finds an ethical battle between professional responsibility, the semantics of medical terminology, and the religion of medicine. The duality of cultures within healthcare can be beneficially utilized through cross-cultural medicine, a necessary incorporation that may greatly progress advancements in medicine.

Under the Hippocratic Oath, acting medical professionals are expected to remain true to the obligations tied to their profession. This includes but is not limited to the responsibility to prevent, alleviate, and remedy sickness, do no harm, treat patients as human beings, and maintain patient confidentiality. These promises are made in word and action, yet, their implications have withstood the passage of time for more than mere tradition: evidence-based commitment. In *The Einstein Journal of Biology and Medicine*, Ralph Hulkover, of the Albert Einstein College of Medicine, speaks on the reason for the upheld principle of the oath, explaining that, “The Hippocratic Oath has endured not because of its specific guidelines and proscriptions but because it represents one’s commitment to…a tradition based on sound scientific investigation combined with patient-oriented care.”[[1]](#footnote-0) The ultimate question of ethics pertains to such a concept as that of *doing no harm*, which after cases of patient and medical dissonance have come up, applies to different cultural understandings of harm–risking patient orientation–such as spiritual damnation as a consequence of medical intervention methods. In revised versions of the Hippocratic Oath used in many medical schools today–due to rising cases and scientific perspectives evolving–a directive mentioned is to avoid “the twin traps of overtreatment and therapeutic nihilism.”[[2]](#footnote-1) Adaptions made to the traditionally recognized responsibilities of medical professionals are to accommodate an increasingly diverse population protected by human rights to believe in their own conscience. Such revision, however, receives criticism regarding whether ethics support the responsibility and conduct to the individual comprehension of healing *or* the scientific basis and laws on which training and qualifications rely on.

The consideration of opposing force to orthodox healthcare comes from the ethical right to autonomy–both that of the individual and family conscience. Upon coming to medical professionals for help in times of crisis and serious ailments, patients do not give up their own minds and hold consensual power over what rituals may be done. Coercion, however, can wrongly be used to force operations that go against patient wishes and take advantage of untraditionally literate individuals. Such manipulation can come in uninformed methods of the medical professionals who habitually use words to describe illnesses that misalign with patients’ vocabulary or conceptual understanding of *disease* itself. Medical training, traditionally, does not prepare professionals for a dynamic where scientific illnesses may not transpose identically throughout cultures. Found in the *Stanford Encyclopedia of Philosophy*, Julian Reiss recognizes this semantic error: “The dividing line between disease and health is notoriously vague, due in part to the wide range of variations present in the human population and to debates over whether many concepts of disease are socially constructed.”[[3]](#footnote-2) Autonomy ultimately requires appropriate and complete communication for informed self-governance. The semantics between cultures, and the literal linguistic barriers not overcome by negligence, can lead to fatality in two worlds: spiritual and physical. In a journalistic account, *The Spirit Catches You and You Fall Down*, Anne Fadiman describes the contention between a Hmong family and healthcare professionals as their daughter faces the serious implications of traditionally diagnosed epilepsy. When the Hmong family, the Lee’s, living in America run to the hospital after their daughter is troubled by serious seizures, the doctors “had no way of knowing that [the parents] had already diagnosed their daughter’s problem as the illness where the spirit catches you and you fall down” and would likely find the issue to be a rather spiritual one. Additionally, the parents were limited by their language and culture, consequently having “no way of knowing that [the doctor] had diagnosed it as epilepsy.”[[4]](#footnote-3) Both religions–medicine and the Hmong–failed to communicate. Most powerfully, medical professionals, ill-supplied by their education, failed to fulfill their duties completely; “...there is an art to medicine as well as a science, and that warmth, sympathy, and understanding may outweigh the surgeon’s knife or chemist’s drug.”[[5]](#footnote-4) Fadiman later wrote in retrospect, regarding the Hmong family’s experience, that “if the Lees were still in [their home country], Lia would probably have died before she was out of infancy, from a prolonged bout of untreated status epilepticus. American medicine had both preserved her life and compromised it. I was unsure which had hurt her family more.”[[6]](#footnote-5) Ethics and educators demand a solution and defined method of conduct, despite varying realities seeming to disrupt each other inevitably.

Enlightening the general dilemma of clashing cultures within medicine, communication and assumptions leave corners cut, and often, different comprehensions of illness are the greatest fault of clashing perspectives at hand. Every medical case of cultural dissonance offers a powerful insight and plea: the religion of modern medicine must incorporate the professionalism of cross-cultural treatment in order to be successful in saving both the body and soul of individual patients. Cultural requests are often discouraged and ignored by professionals because of instinctive bias or lack of respectful inquiry. Ultimately, life and death–illness and wellness–must become a common language in order to deliver the best treatment to individuals. The fact is that body and soul may be treated coherently–demanding sensitivity and properly trained professionals in the psychology and conduct of cultural cases. Traditionally, medical professionals are taught by protocol. They are not often instructed and are rather unprepared for such cases when their life-saving techniques might be considered as even murderous attempts to other cultures. It is their own perception. Describing the justified, uneducated medical professionals through their experience of quite lacking comprehension behind the set principles they’d grown with, “they could hardly be expected to ‘respect’ their patients’ system of health beliefs, since the medical schools they had attended had never informed them that diseases are caused by fugitive souls and cured by jugulated chickens. All of them had spent hundreds of hours dissecting cadavers… but none of them had had a single hour of instruction in cross-cultural medicine.”[[7]](#footnote-6) Put simply, “What the doctors viewed as clinical efficiency, [the opposing culture] viewed as frosty arrogance.”[[8]](#footnote-7) Doctors are not villainous for their lack of cultural sensitivity, but rather, are uninformed and lack preparation for the cases presented. Just as medicine religiously lives by lawful, set protocols that cannot be ignored without grave consequences, culturally sensitive individuals follow their own traditions by necessity–life or death. It is the responsibility of medical professionals to save lives and understand how they can best do so–especially when their practice threatens life in a way they do not naturally comprehend but could be communicated through the effort of both parties.

Researchers of cross-cultural medicine suggest a point in which medical metanarratives overwhelm the opportunity for open narratives and reciprocal communication that are crucial to healthcare efficiency: inquiry. Continuing an investigation of the fundamentals of medical research and practice, Reiss explains that “the usual way of proceeding in a clinical setting is to ask the patient to articulate what is ailing him or her, and thus to use a standardized reporting format to detail various symptoms which represent *subjective* manifestations of the illness or disease. In addition, clinicians perform various tests and examinations that allow more objective manifestations or signs to be recorded, such as heart rate, blood pressure and count, reflexes, and so on. A perennial debate in the philosophy of medicine is what constitutes symptoms and signs and whether they are in fact distinct, which relates to deeper issues about the realism of disease conditions as discussed above.”[[9]](#footnote-8) In addition to procedural logistics such as questions that invite interpretations–allowing physicians to find treatment on an appropriate plane of communication–medical professionals may be encouraged to incorporate cultural diversity in the workplace where possible. Sensitivity and humility allow for science to advance in ways not anticipated, creating an environment where translators, spiritual healers, and healthcare workers can find balance and enhancement. In a case study of cultural dissonance presented to the San Francisco General Hospital Medical Center, Jessica H. Muller, Ph.D., suggested that an “increased sensitivity and understanding might not…alleviate[ ] the frustration of the health care professionals, but it might [make] things more understandable to them and defuse[ ] the emotional intensity of the situation. For physicians who are struggling with the intricacies of bioethical dilemmas, being sensitive to the cultural beliefs and practices of their patients and yet maintaining their own moral integrity ultimately require a juggling act that is difficult for even the most thoughtful and compassionate professionals to manage.”[[10]](#footnote-9) However challenging it may be, it is a developing element to the field in which medical professionals have submitted themselves to and hold the responsibility to manage such bioethical contentions with a minimum degree of sensitivity and awareness–all possible through the adept training which qualifies such professionals from the start of their careers.

Cultural coexistence is to live in a society of autonomy and respect. Healthcare professionals, serving the public in such a challenging and evolving field, are under oath to develop cultural competence; academic institutions of medicine must prepare future physicians for a field that addresses diseases–unlimited by scientific explanation.

Word count: 1561

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