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by

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Abstract

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by

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Lack of adequate health care is a problem for many members of Third World groups. The Third World population is a growing one in major urban areas in the United States and is a population that has significant health needs. Coupled with this is the growing problem of chronic disease which is the leading cause of disability and death among all groups today. Because chronic illness creates a special dependency of clients on professionals that may be inconsistent with the familiar conventions of their lives, members of Third World groups with chronic illness may find themselves in medical situations in which the clash of cultures is particularly significant in determining their health-related behavior. The research that follows deals with problems that emerge when members of Third World groups suffering from chronic disease make contact with health professionals. Our contention is that a conflict emerges between the culture of the health care sys-

tem and the healing cultures of Third World ethnic groups.

There may be many consequences that result on both sides of this conflict. We are interested in the impact the conflict has on health-related behavior, especially the utilization by Third World groups of healing resources that are available in urban areas. It is the thesis of this dissertation that one way in which persons from Third World groups resolve the cultural conflict between systems is to engage in a pattern that we call dual utilization. This pattern involves the utilization of healing resources from both the mainstream health care system and a culturally sanctioned indigenous healing system. We hypothesize that people who adhere to culturally-established health beliefs are more likely to display a pattern of dual utilization than people who adhere to the beliefs of scientific medicine. If this is the case, it is then incumbent upon the health care system and its practitioners, as far as policy is concerned, to become culturally sensitive on both a structural and interpersonal level in the approach toward healing and toward clients or potential clients of the health care system.

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Preface

This project was originally proposed in the context of the community service component of the Multipurpose Arthritis Center at Downstate Medical Center, State University of New York (DMC-MAC). The DMC-MAC is one among many Centers nationwide that are funded by the National Institute of Arthritis, Diabetes, and Digestive and Kidney Disease in the National Institutes of Health (NIADDK-NIH) to conduct research and educational programs in the field of arthritis and the rheumatic diseases. This study was subsequently funded by the NIADDK-NIH and partially supported by an Arthritis Foundation Research Fellowship that was awarded to the author. It was intended to provide in-depth information about the operations of clinics and experiences of clinics. For this reason, two different but complementary approaches were adopted: field observation with qualitative analysis of data, and survey research. The aspect of the study that is emphasized here is primarily based on the analysis of the survey data, though the field phase of the research provides much of what will be described as background or context.

Chapter One discusses the significance of culture to health. It looks at the healing cultures of both the health care system and Third World groups in the United States and the resulting conflict that emerges when mem-

bers of the latter find themselves dependent upon agents of the former. Chapter Two looks at some of the ramifications of this conflict and focuses on patterns of utilization of the health care system in order to evaluate its effects and offers an approach to the study of utilization in terms of the significance of culture and cultural differences. Chapter Three presents the major research hypotheses and describes the research design and sample. Chapter Four reports the findings and discusses them. Finally, Chapter Five discusses some of the policy implications of the research for medical practice and implications for further research.

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Chapter One: THE CULTURAL SIGNIFICANCE OF HEALTH

This dissertation is intended to contribute to that area of medical sociology that deals with utilization of medical services in clinical contexts in which the interaction of physician and client is at issue. It focuses on the significance of cultural differences that often exist between representatives of the health care system and members of culturally integrated Third World ethnic groups.[1] The issue of this chapter is the significance of culture for understanding health beliefs and practices.

The following encounter is based on an observation by the author in the course of carrying out field work in the rheumatology ambulatory clinic at a major teaching hospital in New York City. The setting was one of the many examining rooms in which the physicians see clients. The client was a middle-aged black woman who was from the West Indies. She repeatedly told the physician that she did not feel well in the morning and, therefore, was unable to get out and go to work. The physician replied each time, "What do you mean?" This was repeated several times and both parties became increasingly louder and angrier with each exchange. Finally, trying to put an end to what had become a confrontation, the client raised her voice and exclaimed: "I don't feel good." The physician responded, while looking at her chart, "If you came when

you had appointments and for the tests, I could help you." Later in the interaction, the client told the physician that she had been applying lemon to the rash on her arms. He asked if it was helping her. She immediately said that it did help. When he asked her to be more specific about how it helped, she admitted that it "really did not help" her, whereupon, he laughed. Throughout the entire interaction the client repeated that she wanted to work, but felt physically unable to. She said that she had been trying to obtain Medicaid since she could only afford certain tests that were needed if she received financial assistance. At the end of the interaction, on her way out of the room, the client exclaimed: "What kind of democracy is this?"

After she left, the physician commented: "She is a disaster. I try to help her. She's been trying to get Medicaid for over a year. I schedule her to come every three weeks and she shows up every six weeks. I'm glad she's leaving." He also said that her illness was not physical and that he did not know whether or not she was really sick. He concluded that there was something peculiar about a system in which people were on disability but worked despite that to make more money. "But that," he added, "seems to be the way it is here."

The question this encounter raises is whether the interaction of the parties represents an inability on the

part of the client to participate in a rational process of diagnosis, or something more complex, perhaps a clash of different rationalities. From the standpoint of the physician the client was both self-serving and foolish. She could not answer specific questions about how she felt, could not listen to what was being asked, had failed to participate in a normal course of tests and diagnosis, had used remedies rooted in superstition, and was aggressive and self-serving. Even the researcher is tempted to adopt this perspective, since the research process is part of the same community of science as medicine. Yet, we are sufficiently familiar by now with what anthropologists have shown over and over again: the responses of people to situations may be unintelligible to observers from a different cultural background or may seem backward or unsophisticated, but there may be a rational basis for action rooted in that background that can become visible as such when it is made explicit. Indeed, sociology and anthropology have always had to deal with the problem of understanding others and the self-righteousness that so often accompanies contact with those whose experience and ways of organizing experience are in one way or another foreign. The example itself cannot provide an answer to whether or not the physician's evaluation is correct or adequate, but the fact that the encounter rapidly got out of hand and the fact that neither party seemed able to

communicate with the other, or at least to establish a semblance of consensus, suggests that a deeper conflict than that of rationality with superstition and recalcitrance may have occurred. With this in mind, it seems at least strategically sound to suggest that the parties may have met in this encounter not as individuals--one seeking advice, the other an expert able to advise-- but as members of communities whose cultures made it difficult for them to continue their interaction no matter how compelling or necessary it may have been for one or both of the parties. This model allows us to consider the possibility that the physician's problem was an inabilty to "hear" the client, and that the client's was a sense of violation due not to a preoccupation with democracy but due to a sense that there was no one to talk to, no one who could understand. One way of investigating this, at least preliminarily, would have been to have observed the client in her community and to see how she speaks with others about her ailments and how she organizes the healing resources of that community in her own interest. That would at least have raised a presumption that there was a greater rationality on her part than the physician was able to grant. In any case, the model--of culture conflict --suggests that patterns of utilization can be understood as a sociological rather than merely a social psychological problem, and that people who visit physicians do not

cease to be members of a community any more than the physicians they visit cease, in the medical encounter, to be part of the ideological setting of medical practice, the culture of scientific medicine, to which they undoubtedly have been socialized and in which they participate.

The focus of this research is on chronic illness as it relates to the cultural milieu of the health care system. Chronic illness creates a dependency and preoccupation with the body. When a person has a chronic illness his or her body is always implicitly involved in healing. We are particularly interested in the chronic illness of arthritis and related rheumatic diseases. The etiology of arthritis and related rheumatic diseases is unknown and there are no known cures.[2] Thus, treatment is aimed at the relief of symptoms that seriously interfere with the individual's well-being. Rheumatic diseases, unlike other chronic diseases such as hypertension or diabetes, typically manifest symptoms that are obvious to the afflicted person. There is variation among individuals as to the degree of disability, pain, and interference with daily activities. The desire to gain relief from symptoms supplies a strong motive to choose some course of action. The social and emotional consequences of chronic illnesses are major issues for the effective care of most people who have a rheumatic disease. They need explanations for what to expect and advice regarding reasonable strategies for coping effectively with their

disease and for handling incidental problems that may arise. There is also a strong need for reassurance about the progress of the disease, in part because the medication prescribed, especially for a disease like osteoarthritis often only ameliorates the symptoms. Consequently, a critical element in effective treatment is having clients understand their disease in terms that make sense to them and those around them and adjusting expectations to reality.[3]

Aside from the physiological aspects of chronic illnesses, there are additional considerations that include sociocultural factors. Growing evidence indicates that social, cultural, and psychological factors have an important role in whether people become ill and in the duration of their disabilities and the intensity of their symptoms. Once a person is afflicted with a chronic illness, effective treatment of the disease often requires a modification of lifestyle and social relationships. Often a necessary component of this adjustment is that the person who is ill, along with family and close friends, take a great deal of the responsibility for the care and the management of the illness. The extent of the change in lifestyle that the person may have to make will depend on the seriousness of the particular case. Ideally, the required lifestyle alterations would be discussed by health professionals with their clients. A successful outcome

depends to a great extent on the quality of the physician--client relationship and the ability to communicate with each other. However, there is an inequality in status and power relations between physicians and clients that is built into the structure of the health care system that has been well documented in the field of medical sociology. If one adds the additional factor of a difference in cultural orientation the relationship suffers even more.

> Broadly speaking, culture is a group's design for living, a shared set of socially transmitted assumptions about the nature of the physical and social world, the goals of life, and the appropriate means of achieving them.[4] At the heart of such designs for living are shared assumptions about the maintenance of well-being and appropriate means of achieving that state, however diversely it may be defined. Such assumptions relate not only to the nature of the the material and social world but also to the nature of the biological world, i.e. to ways in which the human body is viewed and seen as functioning. Body image and anatomical knowledge are fundamental in this regard, as are ideas about disease causation, symptom, diagnosis, treatment and other facets of health.[5]

These shared assumptions refer to beliefs or belief systems.

> A belief is a hypothetical construct that involves the assertion of a relationship between some attitude object (a person, a situation, or a behavior, such as smoking) and some attribute of that object (e.g. causes of cancer).[6]

All cultures incorporate beliefs related to healing and illness. Therefore, if we view this fact cross-culturally, we find a variety of health beliefs and corresponding behaviors. Moreover, we shall argue that the health care system in the United States has its own healing culture

that is dominant, namely scientific medicine. On the other hand, Third World groups living within the United States have distinct healing cultures which may incorporate to greater or lesser extents aspects of the mainstream health care system. More significantly, it is the contention of this dissertation that there is a clash between the culture of the health care system and the healing cultures of Third World ethnic groups. The culture of the health care system, as represented by the iomedical perspective or scientific medicine incorporates assumptions and imperatives for its health care professionals. On the other hand, Third World groups (and all cultural groupings for that matter) have their own assumptions and imperatives for its members which are in conflict to varying degrees with the assumptions and imperatives of the culture of scientific medicine. As a result, each group is resistant to the other's culture and cultural prescriptions regarding health and illness.

> When the practice of medicine involves the application of elements of the institution of medicine in one culture to the people of another, or from one subculture to members of another subculture within the same cultural group, what is done or attempted by those in the healing roles may not be fully understood or correctly evaluated by those in the patient roles. Conversely, the responses of those on the patient side of the interaction may not conform to the expectations of those on the healing side. To the extent that this occurs, the relationship may be unsatisfactory to everyone concerned. . . . When persons of widely dissimilar cultural or subcultural orientations are brought together in a therapeutic relationship, the probability of a mutually satisfactory outcome may be increased if those in the healing roles know something of their

> own culture and that of the patient and are aware of the extent to which behavior on both sides of the relationship is influenced by cultural factors. An even higher probability of satisfaction may result if the professional people are willing and able to modify elements from their medicine so as to make them fit the expectations of the laymen with whom they are working.[7]

Chronic illness requires an ongoing relationship between the client and the health care system. Therefore, contact with physicians and other health professionals are unlike those for acute episodes of illness which have a defined duration. The ongoing treatment brings together individuals who are usually from different cultural backgrounds. Given this set of circumstances, it is incumbent upon health professionals to familiarize themselves with the "whole person" including the social and cultural influences on the individual's life. The fact that a great number of people receive treatment outside of the health care system, either at home or by culturally traditional healers, should be recognized and incorporated in some fashion into treatment plans.

Since living successfully with a rheumatic disease involves establishing a meaningful exchange of information and ideas between practitioners and clients, a marked cultural distance, even independent of language barriers, makes the establishment of rapport and communication difficult, particularly around such sociocultural concerns as sexuality and diet. In addition, beyond the normative role of culture, it is likely that the symptomatology of

the rheumatic diseases and the lack of a cure may encourage people to rely on culturally sanctioned or other alternatives to the health care system that are thought to be efficacious.

In discussing the significance of understanding cultural differences for health and healing, Saunders has the following to say concerning what appears to be lack of adherence or ignorance on the part of the client who differs culturally with the practitioner:

> If such behavior can be seen and interpreted as an expression of cultural conditioning rather than as simply the whimsical result of individual deviance, it becomes possible to anticipate it and to devise effective ways of changing it or of adapting to it.[8]

Knowing the cultural orientation of the client and the possible bearing it may have on the client's behavior is important to the practitioner's strategy. The practitioner needs to know the extent to which cultural orientation influences behavior of clients.

> So equipped, he [sic] is able to see uniformities in and reasons for kinds of behavior that otherwise might be ascribed to individual perversity, indifference, apathy, or ignorance and to so direct his [sic] own behavior as to obtain the desired patient response.[9]

The Culture of the Health Care System

Let us now briefly examine the culture underlying the present health care system in our society. In addition to health care reflecting the norms, values, beliefs, and expectations of the larger society, the institutionaliza-

tion of health care has generated its own culture of healing. Like all cultures, this one legitimizes beyond technical criteria, the healing claims of scientific medicine and incorporates into the practice of health professionals the class relations and established social divisions of society.

The history of modern medicine represents a triumph of science and profession over traditional healing and healers. Women had been the primary practitioners of healing in traditional societies.[10] With the emergence of formally trained and officially credentialed doctors, who were largely male, in a context of industrial development and its corresponding technologies and corporate controls, the twentieth century saw the creation of a new profession with control over the definition of medical knowledge and the certification of practitioners.[11]

Thus, modern medicine came to exclude traditional culture, and with it women healers, as in any way important to the process of healing. The ascendance of physicians in the social and economic hierarchy of United States society made legitimate not only their authority over healing but the exclusivity of that authority. This suppression of culture in the process of healing has had extra-institutional consequences as well. It has redefined human well-being as freedom from disease rather than, as before, the reintegration of the person in his or her cultural group.

The development of modern medicine must be seen as part of distinctive social and economic changes that took place from the early to the mid-nineteenth century, in particular the division of the economy into two relatively separate spheres: domestic and industrial/financial.[12] Domestic life became relatively isolated as the province of women and the center of social reproduction, leisure, and community. As such, it was seen as a sphere of essentially socioemotional activity unable to contribute to those areas of life in which science, technology, and economy had become predominant rationalizing forces. Sociologically, this division implies (1) classes in the "productive" sphere; (2) the super-imposition of gender on the differences between those who worked for a wage and those who worked in the home; (3) an ideological distinction between the "rationality" of industry and the market and the merely "expressive" quality of domestic, interpersonal, and community life; and (4) an incorporation of these distinctions into the specialized practices of "professionals" to the detriment of all that could be associated with the domestic sphere. For medicine, this meant a shift from a healing culture based on traditionalism or a unity of labor and community to a professionally oriented healing culture that conformed to the separation of labor and community.

The approach of scientific medicine, or the biomed-

ical perspective, focuses on objective and rational explanations and treatments for disease. It is only recently that an interest in health promotion or "wellness" has developed. Many physicians tend to see their "patients,"or "patients'" bodies as objects for analysis rather than aspects of persons, and see themselves as specialists to distinct parts of the body and as experts about the body's condition. They, consequently, are unable to grant rationality and relevance to clients' judgments and healing inclinations or to appreciate the significance of the social, cultural, and psychological factors that operate as inevitable and necessary features of the healing process.

There are several practical consequences of the institutionalization of the professional's culture and the establishment of the legitimacy of its control over healing. First, it becomes difficult to recognize that a valid and responsive healing program must be more than just a treatment plan. The health professional's culture excludes, as a matter of principle, the healing inclinations and sanctioned healing practices established within the client's own culture; an exclusion the client cannot, and in any case often does not, accept. Further, it becomes difficult for the medical encounter to provide an opportunity for client and professional to reconcile their health-related cultural differences and, therefore, for the client

to arrive at a rational--livable in his or her own terms--basis for adhering to the treatment plan. Indeed, the culture conflict dictated by an exclusively rationalistic approach to medicine may leave the client without an adequate basis for interpreting diagnosis and advice. Even more significant is the fact that this approach may force the client to decide between a medical regimen imposed from outside and one inextricably tied to the deepest moral values and practices of the clients' culture. Finally, as can be seen from the encounter described at the beginning of this chapter, a failure of the health professional to find a basis for a cultural reconciliation may reinforce already existing biases making it difficult to adequately appraise the client's needs.

In sum, the history of scientific medicine has promoted an ideological position in the sphere of healing which has conformed to the shifts in the sphere of production. So not only were new medical models being used but the people who were considered knowledgeable about these models were a new group of people. Thus, the shift to the hegemony of scientific medicine has meant the usurpation of knowledge concerning health and well-being from the community and giving "specialized" knowledge to a small group of professionals whose position is sanctioned by the larger society.[13]

The Cultures of Third World Clients

The fact that clients bring with them not only a presenting problem but knowledge, experiences, beliefs, and traditions is usually not taken into consideration in the practice of scientific medicine.

> In every way, the health institution is viewed as acting upon, impinging upon, or being introduced into communities or specific population groups to inject something into their lives that they do not already have. While this may be a laudable undertaking in the interest of sharing the specific health-related strengths of the orthodox system, the problem lies in the unicultural focus underlying such efforts. Reality is perceived in terms of introducing *something* where *nothing* of significance existed before. The acknowledgment that individuals and communities have *something* already, such as their own health cultural traditions, is not required by the concepts in current use by orthodox providers of health care.[14]

It is unquestionably true that clients or potential clients play active roles in their health and medical care. They make decisions based on their beliefs, self-perceptions, and the weighing of costs and benefits. If they seek medical advice, they choose whether and to what extent they will follow recommendations, and they decide the conditions upon which recommendations will be followed. In making these choices, clients cannot avoid conforming to the beliefs, expectations, values, and norms of their cultural settings. These decisions may involve seeking the advice of people outside of the health care system who are significant to evaluating their health and healing such as relatives, friends, and culturally indigenous and sanctioned healers, and engage in traditional

healing practices.

The cultural imperatives that people adhere to may be largely derived from the culture of the ethnic group of which the individual is a member or in which one at least has his or her origins. The power and class relations associated with ethnicity are part of the development and experience of every individual in our society. Therefore, it is reasonable to assume that they are unavoidable features of practitioner-client interactions. This complex of factors is particularly important in the medical experience of Third World ethnic groups who are among the most oppressed segments of the population.

It was felt that a study focusing on Third World groups would highlight the cultural differences that may be found between mainstream health care and the health practices of certain portions of the population. This focus also allows a view of urban health practices that may not always be obvious to interested parties.

It has been well established by sociologists and anthropologists that Third World ethnic groups that are victims of institutional racism[15] tend to maintain relatively independent cultural forms.[16] Evidence indicates that a wide range of resources, including health care, are underutilized by this population. The causes of this underutilization are complex, partly because of the intricate relationships among subordinate status, political

power, poverty, and education, and partly because of the effects of discrimination on attitudes and behavior. Studies in sociology and anthropology have suggested several important ways in which the cultural aspects of ethnicity influence health beliefs, perceptions, attitudes, and behavior. Third World ethnic group cultures, in particular, often approach health and illness in ways that differ from that of scientific medicine.

Traditional health beliefs and the culturally sanctioned utilization of traditional healers are well established in Third World cultures. The operation of these alternatives can be illustrated by a summary derived from previous research[17] and field work by the author. In Latino communities many people adhere to a caliente-frio (hot-cold) theory of illness. According to this belief an illness will manifest itself when the body experiences an imbalance between hot and cold. In this scheme foods, medications, and herbs are classified as caliente o frio. (hot or cold) When an imbalance occurs, the person must be given the appropriate items in order to restore his or her health. Arthritis is considered to be the result of an external cold that lodges in certain areas of the body. Therefore, appropriate treatments are medications, foods, and herbs that are classified as caliente in order to restore the body's balance. Someone who holds these beliefs may turn to a botanica (herb shop) as a source of care.

A botanica is consulted for both herbal and spiritualist remedies. The person with arthritis may want to obtain herbs and teas or tonics that are caliente. In addition to, or instead of, an herbal remedy, the person might seek the help of a spiritualist, who is a medium, who may find a supernatural or psychic cause for the problem and recommend a strategy for eliminating it. A botanica may be used as a source of care either before or after consulting a physician or may be used simultaneously with a physician's care. It is not unusual for spiritualists, for example, to recommend to their clients that they see a physician along with their own recommendations for treatment.

Following are some of the ways in which culture and health are interrelated. First, concepts of illness including etiology vary according to cultural background. Social psychological, environmental, and supernatural influences may be emphasized in the etiology of illness. In addition, there are occurences that are classified as illness in some cultures which are not found in others, for example, mal de ojo[18] (evil eye) which is recognized in the Puerto Rican and Mexican cultures and cultures surrounding the Mediterranean.

Second, some cultural groupings recognize models of bodily functioning and good health that are different from and inconsistent with the biomedical model, for ex-

ample, the caliente-frio model discussed above. Beliefs derived from these models lead logically to the use of traditional healing practices as well as of traditional healers, though not necessarily to the exclusion of scientific medicine. Third, cultural groups vary in their perception of and response to illness. For example, Zborowski[19] has shown that the perception of pain and the response to it vary among different ethnic groups. Fourth, cultural background affects communication patterns between client and health professional as a result of both cultural distance and culturally influenced styles of interacting with other people.[20]

Although we have been discussing the importance of cultural factors for health care, we must also recognize that differences exist within cultural groups as well. Not to recognize these differences is to stereotype the members of groups. Health professionals should be able to use the cultural information they have about clients to provide general guidelines for evaluating the extent and the ways in which the medical encounter need to be modified to fit culturally based expectations.

In summary, we propose to study the issue of cultural differences and how they relate to medical care. We would like to know what happens when health professionals confront clients whose cultural orientations may be in conflict with the orientation of the health care system.

We would argue that the differences in orientation which are manifested in a number of ways (e.g., lack of adherence to treatment plans, underutilization, etc.) are rooted in cultural explanations for beliefs and behaviors and not in lack of education or sophistication or in deviant beliefs and practices. Furthermore, it is our contention that social supports exist for the traditional cultures of Third World groups that do not necessarily exist for other groups in urban areas. Therefore, there are sanctioned alternatives for Third World group members to choose from for which they receive social approval. We will turn our attention now to look at the implications of this conflict and a strategy for its resolution.

NOTES

[1]Those ethnic groups whose members originate in Third World countries, i.e., countries in Africa, Asia, South America, and Latin America.

[2]Gerald P. Rodnan and Ralph H. Schumacher, eds., Primer on the Rheumatic Diseases, 8th ed. (Atlanta, GA: The Arhthritis Foundation, 1983).

[3]Interview with Mitchell Forman, D.O., rheumatologist and Project Director, SUNY-MAC, 1982.

[4]Benjamin Paul, "Anthropological Perspectives on Medicine and Public Health," Annals of the New York Academy of Political and Social Science 346 (1963), quoted in Hazel Hitson Weidman and Janice A. Egeland, "A Behavioral Science Perspective in the Comparative Approach to the Delivery of Health Care," Social Science and Medicine 7 (1973):848.

[5]Weidman and Egeland, p. 848.

[6]D.J. Stang and L.S. Wrightsman, Dictionary of Social Behavior and Social Research Methods (Monterey,CA: Brooks-Cole, 1981) quoted in M. Robin DiMatteo and D. Dante DiNicola, Achieving Patient Compliance (New York: Pergamon Press, 1982), p. 123.

[7]Lyle Saunders, Cultural Differences and Medical Care: The Case of the Spanish Speaking People of the Southwest (New York: Russell Sage Foundation, 1954), p. 8; emphasis in the original.

[8]Saunders, p. 99.

[9]Ibid.

[10]Barbara Ehrenreich and Dierdre English, For Her Own Good (Garden City, NJ: Anchor Press, 1978).

[11]Howard S. Berliner, "A Larger Perspective on the Flexner Report," International Journal of Health Services 5 (1975):573-92.

[12]Alice Kessler Harris, Out To Work: A History of Wage-Earning Women in the United States (New York: Oxford University Press, 1982).

[13]c.f. Ehrenreich and English; Berliner; and Eliot

Friedson, Profession of Medicine: A Study of the Sociology of Applied Knowledge (New York: Harper and Row, 1970).

[14]Hazel H. Weidman, Miami Health Ecology Project Report: A Statement on Ethnicity and Health, vol. 1, University of Miami School of Medicine, 1978. (Mimeographed.) Quoted in Alan Harwood, ed., Ethnicity and Medical Care (Cambridge: Harvard University Press, 1981), p. 22; emphasis in the original.

[15]Stokely Carmichael and Charles V. Hamilton, Black Power: The Politics of Liberation in America (New York: Vintage Books, 1967).

[16]Franz Fanon, The Wretched of the Earth (New York: Grove Press, 1968).

[17]M. Delgado, "Herbal Medicine in the Puerto Rican Community," Health and Social Work 4 (1979):24-40; Harwood; and I. Murillo-Rohde, "Cultural Sensitivity in the Care of the Hispanic Patient," Washington State Journal of Nursing, special supplement (1979):25-32.

[18]Mal de ojo is an explanation for the sudden onset of illness in a child which comes about when an adult, usually an acquaintance of the family, has shown the child an inordinate amount of attention.

[19]Mark Zborowski, "Cultural Components in Responses to Pain," Journal of Social Issues 8 (1952):16-30.

[20]c.f. Harwood.

Chapter Two: CULTURAL INFLUENCES ON UTILIZATION

This chapter reviews the literature that deals with the issues that have been raised in Chapter One in relation to culture. There are several possible consequences that may emerge as a result of the cultural clash between Third World groups and representatives of the health care system. Of fundamental importance is the communication between health professionals and clients. Unless there is some recognition by the practitioner of the cultural differences and an incorporation of these differences into his or her approach, the likelihood is that the communication process will suffer. The distortion that arises as culturally different individuals communicate has to do with the inability to focus on the relation of need and practices and to suppress that focus in favor of tangential issues. Given the decay of communication, treatment plans are likely to suffer either in the controls necessary for an evaluation of their success or in the actual choice and use of remedies. Other possible consequences have to do with the utilization behavior of members of Third World groups so far as both preventive and illness behavior are concerned. These practices may include failure to keep appointments, lack of utilization, or other variations on utilization. An example of a variation on utilization behavior is the phenomenon of dual utilization which we

will be discussing below. Briefly, this pattern of behavior has to do with the utilization of resources of both the mainstream health care system as well as a traditional healing system.

The focus of this study is on utilization patterns that are direct manifestations of cultural differences. If a distinctive pattern of utilization for Third World clients can be shown, then it may be possible to study the ways in which it corresponds or fails to correspond to the clash of cultures in the treatment process in a clinical context. Since the literature in the field of the use of health services is vast and spans several disciplines, a brief overview will be provided and a subsequent concentration on the experience of Third World groups in the United States will follow.

Andersen and his colleagues[1] developed a descriptive model for the use of health services that proposes that utilization depends on "predisposing," "enabling," and "illness" types of variable. The predisposing variables include social psychological, cultural, and demographic factors. Enabling variables include the differential availability of services and economic conditions such as income level and possession of health insurance. Illness variables include perceived need based on symptoms, diagnosis, and disability. All of these may be helpful in predicting the use of those health services that include physician services, hospitals, drugs and medications,

dental services, and other health-related services such as nursing homes. The following pages report the trends that have been found for the above variables that are relevant to this dissertation. These trends have been published in a National Center for Health Services Research publication entitled, The Use of Health Services: Indices and Correlates,[2] a survey of research conducted on utilization up until the time of publication.

Since the late 1950's the proportion of the population seeing a physician has increased while the mean number of visits has decreased. Approximately three-fourths of the population saw a physician in 1978. Since the early 1960's the use of a physician's office as a site for care has decreased, while the use of clinics and emergency rooms has increased. The sociodemographic factors that have an important role in predicting utilization are age, gender, race, and education. The long-term trend has been that the old, the young, women, and whites are more likely to use health services than others. Education is correlated with the use of preventive services, but its relationship to the use of health services in general is unclear. Cultural and social psychological factors are helpful in explaining the use of physician services, in particular, preventive care. High correlations have been found with satisfaction with care, knowledge, social support, and stress. As far as socioeconomic status is concerned, the

poor now use physicians more than others probably due to new forms of financing, for example, Medicaid. However, evidence suggests that the poor do not use physicians at levels adequate to their need and are less likely to use preventive services than might otherwise be expected. The trend has continued for the poor to use more hospital services than other groups. Perceived need continues to be the best predictor of nondiscretionary health services.[3]

Before going on to the literature that looks specifically at cultural factors, a critique of the general body of literature on utilization can be made from the vantage point of the present study. Most of the research in this field focuses on quantitative and not qualitative differences in utilization behavior. That is, the emphasis is on volume of the use of health services in relation to the many variables that have been thought to explain this behavior. What is not reported are the qualitative aspects of these relationships. So that, for example, we know very little about the characteristics of health professionals and how these affect patterns of utilization. On the other side, we get very little sense, for example, of additional resources that clients may be utilizing instead of or along with the health care system. There are few studies which include or assess the use of alternative practices to scientific medicine as part of the body of research on the utilization of health services.

We would like to look now at cultural and related factors that have been studied in the literature that will provide a background for studying the utilization patterns of Third World ethnic groups. We are excluding the literature in the fields of psychiatry and psychology which concerns the relationship between practitioner and client in the context of cultural differences. An abundance of research on this topic exists in these fields and, as a consequence, therapeutic relationships in some cases have been altered. A stronger case can be made if the cultural argument could be made in relation to physical problems as well as psychological ones. In addition, as a result the psychological/psychiatric approach may be validated.

Most studies which have been concerned with the health orientations and behaviors of Third World groups, especially those concerned with the underutilization of medical services, essentially fall into three categories. The first has to do with the inadequacies of the structure of the health care system as well as unequal access to medical facilities due to lack of financial resources and physical barriers to care.[4] In fact, it is reasonable to conclude that two separate systems of health care have evolved. The "private system" that serves the middle and higher socioeconomic strata of our society and the "public system" that serves those in the lower socioeconomic strata. While neither system is free of difficulties, clients

of public services meet with a number of special problems.[5] These include long waiting periods, little continuity of care by the same practitioner, insufficient time spent with health professionals, an impersonal atmosphere, and inferior physical settings. The fact that Third World groups are often confined by poverty and other factors to the "public system" of health care is an important consequence of institutional racism. Within this context there are specific problems that have to do with communication between health professionals and clients and the individual effects of ethnocentrism[6] among health professionals.[7]

The second category consists of studies that use the "culture of poverty"[8] concept to account for the underutilization of medical care. This concept refers to a way of life that the poor supposedly adapt to as a result of their poverty which perpetuates maladaptive social and psychological traits. One of these social maladaptations is the inadequate use of medical care which is a reflection of the alienation and isolation of the poor from the larger society. Underutilization is seen as a direct result of the culture and values of the poor and the poor themselves are seen as responsible for their own position in society. The policy implications that flow from this position focus on changing the culture and values of the poor and ignore the structural inequalities of the health care system. This approach has been widely criticized[9]

in its general conception and in relation to health care.[10] The studies that fall into the "culture of poverty" approach do not differentiate between the effects of poverty and cultural differences based on ethnicity. Their use of the term culture is therefore conceptually inappropriate.

Studies in the third category of interest, the sociocultural differnces approach to the underutilization of health services, look at complex cultural factors and socioeconomic factors which influence utilization patterns and other behavioral responses related to health and illness. Also, many of these studies view medicine itself as representing a cultural perspective which may influence utilization behavior. The approach that is taken in the present study falls into this last category. Cultural differences is viewed as one among several salient explanations for the underutilization of health services.

A review of the significant studies that are relevant to a perspective of sociocultural differences with an emphasis on cultural differences follows. As was discussed in the first chapter, beliefs are an important component of culture and, therefore, it would be helpful to study health beliefs in the context of cultural differences. One of the most influential approaches in explaining health behavior is the health belief model used by Becker and others.[11] This model is largely based on the social psychological approach of Lewinian "field theory"

that puts forth the idea that people live in a space that is made up of regions with positive and negative valences. People are repelled by regions with negative valences and are attracted toward positive valences. So a person's behavior is the result of seeking the most attractive balance among different values. Within this context, behavior depends on two variables: the value placed upon a particular outcome and the belief that a given action will result in that outcome. The health belief model makes the assumption that by taking a particular action, susceptibility to illness would be reduced, or if the illness occurred, severity would be reduced. Perception of the threat to health and cues for action are modified by demographic, social psychological, and structural (e.g., contact with a disease) factors. This model assigns a great deal of importance to a person's subjective assessment of a situation rather than medical diagnosis to explain the use of health services. A drawback of this model that has been recognized is that it is only applicable to preventive health behavior and not to illness behavior. Furthermore, the health belief model does not have a cultural grounding, therefore, insufficient care is taken to distinguish subjective evaluations based on the situation and those that are relevant to the individual's membership in and obligations to his or her group. The title implies a model of how health beliefs will affect behavior, but,

in fact it operates independently of cultural concerns about health and healing that are known to have relatively stable influences on beliefs.

Moving into the context of culture, Zborowski's[12] study in New York City demonstrated the existence of cultural differnces with regard to attitudes toward pain and responses to pain. Although there were no Third World groups or women included in the study, the findings contribute to our understanding of the relationships between culture as derived from ethnicity and illness behavior. The groups that were included in the study were Italian, Jewish, and "Old American." Zborowski found that Jewish and Italian clients responded in a sensitive and emotional manner to pain with a tendency toward exaggeration. "Old Americans," on the other hand, were more stoical and objective in their response. Attitudes toward pain varied among the groups as well. Italian clients were primarily interested in obtaining relief from pain. Jewish clients seemed to be more concerned with the meaning and significance of pain and their future well-being. Also, they were skeptical about their physicians and using medication. The "Old Americans" were similarly concerned about the significance of pain, for their general well-being, but displayed confidence in their physicians and use of medication. The overall findings demonstrate that in addition to the differences in attitudes and responses

to pain, behavioral manifestations of pain do not necessarily reflect actual attitudes toward pain. This distinction is seen for Jews and Italians who exhibit similar behaviors in response to pain, but, maintain different attitudes toward pain. Secondly, similar behavioral manifestations may have different functions and serve different purposes for different cultures. There was a similar distinction between attitude and behavior with reference to generation in the country. Later generations are more "American" in their behavior. However, attitudes toward pain seem to persist despite these behavioral changes. Educational differnces similarly did not change attitudes, but, did modify behavior.

Zborowski views these differnces in attitudes and behaviors as emanating from the early socialization process in which different attitudes toward illness are taught. Zborowski's study demonstrates cultural differences between groups particularly in their health-related attitudes which appear to be deeply culturally ingrained. However, these attitudes were not always related to behaviors associated with pain.

In 1966, Zola's study in New York City of the cultural influence on the reporting of symptoms was consistent with Zborowski's findings. Zola found that Irish and Italian clients in presenting their symptoms manifested different attitudes toward their complaints as well as

toward their overall health. Italians dramatized their symptoms, while the Irish tended to deny their symptoms. He attributed these differences to culturally prescribed ways of handling problems in the respective cultures. As far as demographic variables were concerned, there was not enough variation in the sample to look at these effectively. Although men and women were included in this study, Zola did not analyze possible differences between them. Again, there were no Third World ethnic groups included, but we find a confirmation of the findings of cultural differences as they related to attitudes about health.

The following are studies that do include the Third World population and look more closely at cultural differences not only between ethnic groups but between cultural groupings and the health care system as well. Saunders, in his book entitled, Cultural Differnces and Medical Care, that was cited earlier, explored the cultural differences between the Spanish speaking people[13] in the Southwestern United States and the mainstream culture particularly as these differnces related to health and healing. Saunders intended to convey two major points in his book. The first was that the practice of medicine is a social sctivity in that it always involves interaction between two or more people (or "socially conditioned human beings"[14]) in a context of a social system.

The second point was that medicine as a social system is a social institution which by itself constitutes a subculture and is part of the larger culture. Since every culture is unique, medical beliefs and practices will vary cross-culturally. Through the use of ethnographic data, Saunders provides evidence that suggests that the healing cultures of the Spanish speaking groups may be incompatible in some respects with the culture of the mainstream medical profession, and this incompatibility may determine health and illness behavior and health status and outcomes. Saunders found that there are differences in belief, knowledge, attitudes, and feelings which are manifested in different cultural orientations toward illness and disease. The differences in approach to illness that he found were in the following areas: (1) the concept of disease, (2) the etiology of disease, (3) appropriate remedies, (4) patterns of relationships between client and healer, (5) conceptions concerning role expectations in the therapeutic relationship, and (6) conceptions of proper roles for relatives and friends. These differences along with lack of availability of, fear of, and dissatisfaction with mainstream health care services often account for the failure of the Spanish speaking to use scientific medicine. Operating within a cultural frame of reference, Saunders felt that age and degree of participation in Anglo culture would be the most important variables associated with cultural differences in belief, knowledge,

and practice with regard to illness and disease.

For the first time in the utilization literature we find a study concerned with Third World healing cultures and the inherent conflict with the culture of scientific medicine. We also find that traditional healing systems are taken seriously within the context of a cultural framework as being consistent with health beliefs and cultural imperatives.

Suchman's[15] study of ethnicity and health-related attitudes and behavior examined ethnic groups and their social organization in a neighborhood in New York City. He focused on five groups: Puerto Ricans, blacks, Jews, white Protestants, and Irish Catholics. He found ethnic differences in regard to health-related knowledge, attitudes, and behavior.[16] Further, he found that these variations are related to the type of social organization within the ethnic group. He distinguished two types of social organization: cosmopolitanism and parochialism.

> . . . with the cosmopolitan end of the scale indicating heterogeneous and loosely knit interpersonal relationships while the parochial end indicates homogeneous and closely knit interpersonal relationships. This measure may be taken to indicate the degree of identification of an individual with a parochial or limited, traditional, narrowly confined, and closely knit 'ingroup' point of view, as opposed to a cosmopolitan or more worldly progressive, 'urban' or less personal way of life.[17]

The Puerto Ricans and the Irish Catholics were highly parochial, white Protestants and Jews were highly cosmopolitan. Blacks were more inclined toward cosmopolitan-

ism than parochialism. Further, he found that the cosmopolitan groups had a greater orientation to scientific medicine and parochial groups had a more "popular," i.e. non-scientific, orientation. Thus, the Puerto Ricans were much more likely to have a popular orientation than any other ethnic group and white Protestants and Jews had the most scientific orientation. Suchman, then, introduced socioeconomic status and found that "lower-class parochial Puerto Ricans" were most likely to have a popular health orientation and "upper-class cosmopolitan Protestants" were least likely to have a popular orientation. The blacks tended to resemble the Puerto Ricans and the Jewish group was closer to the Protestants on health orientation. His general conclusion was that form of social organization rather than ethnicity or social class is more important in predicting health orientation.

With Suchman's study we get the first attempt to measure orientations toward health. He concludes that the form of social organization within an ethnic group is the leading factor in determining healing orientation. By focusing on social organization, however, he does not include actual cultural elements in his argument. His conclusions have been criticized in the literature from different perspectives. He has been criticized for using a "culture of poverty" interpretation for his findings, particularly for the findings concerning the Puerto Rican

group.[18] Geertsen and his colleagues[19] replicated Suchman's study in Salt Lake City and found an opposite trend, i.e., parochialism may increase the likelihood of adherence to a scientific orientation to health. They, also, conclude based on their findings that a group's cultural beliefs and not social organization determine health orientation.

More recently, Berkanovic and Reeder[20] in their study in Los Angeles County found that culturally based value prefernces as determined by ethnicity and socioeconomic status are important determinants of source of medical care used by individuals. Source of medical care was dichotomized into (1) private physicians and (2) clinics and emergency rooms. People in the survey who had been ill or injured in the past year were asked if they had seen a physician and if they had were asked where they had seen one. Berkanovic and Reeder found evidence to supoort their hypothesis which they stated as follows:

> . . . there are diverse value preferences with respect to the source of medical care which individuals use, and . . . these value preferences are part of distinct subcultures in American society, which are linked to ethnicity and socioeconomic status.[21]

They also analyzed the relationship between Suchman's organization types, cosmopolitanism and parochialism and source of medical care and did not find a statistically significant relationship. Based on their findings they conclude with a policy recommendation that health services be planned pluralistically in order to accommodate cult-

ural differences. Although Berkanovic and Reeder focused on socioeconomic as well as cultural differences, they provide evidence that is indicative of cultural differences related to utilization. In addition, they raise the issue of source of care in relation to cultural differences which many studies do not include.

Having raised source of medical care as an issue, it is now possible to consider sources of medical care that are external to the mainstream health care system. Several studies are relevant. Freidson[22] introduced the concept of the lay referral system which he used to refer to a network of consultants ranging from close relatives to distant knowledgeable laypersons with a foundation of cultural understandings. Through this system an individual may end up seeking professional services or may seek the help of a lay consultant or folk practitioner. Freidson distinguished between two types of lay referral systems: one in which the culture is of maximum congruence with that of health professionals and the referral structure is minimized, the second is based on an indigenous lay culture and the lay referral structure is extended.

> The indigenous, extended system is an extreme instance in which the clientele of a community may be expected to show a high degree of resistance to using medical services. Insofar as the idea of diagnostic authority is based on assumpted hereditary or divine 'gift' or intrinsically personal knowledge of one's own health, necessary for effective treatment, professional authority is unlikely to be recognized at all. And, insofar as the cultural definitions of illness contradict those of professional culture, the referral pro-

cess will not lead to the professional practitioner.[23] Freidson's concept of the lay referral system allows for the possibility of some amount of client (or potential client) control or influence in the seeking of medical care. It also allows for the possibility of using practitioners that are outside of the mainstream health care system as being not only a logical choice but a culturally sanctioned one as well.

Following are two empirical studies that focus on the utilization of practitioners both outside of the mainstream health care system as well as within the mainstream system. Each study represents a different theoretical orientation to this pattern of utilization. Roebuck and Quan[24] studied the utilization patterns of low income blacks and whites in a Southern rural setting. The objective of the study was to compare these two groups on medical and treatment orientation in their utilization of practitioners and remedies that were categorized as either legitimate or illegitimate by the authors. Going outside of the health care system for treatment was considered deviant health practice. Consequently, folk or traditional practitioners were categorized as "illegal healers." The findings from this study did demonstrate differences in utilization between blakcs and whites in the extreme cases, i.e. blacks were more likely to utilize "illegal healers" only. However, both groups significantly util-

ized a combination of mainstream and non-mainstream health care (i.e. dual utilization) with blacks overall less oriented toward scientific medicine. As far as remedies were concerned, there were no significant differences between whites and blacks on the utilization of remedies from both systems. Although this study adds to our awareness of alternatives to the health care system, and suggests that dual utilization may not be as unusual as is generally thought, the emphasis on deviance directs the authors' efforts away from a cultural explanation for utilization behavior.

In contrast, Press[25] reports on "dual use" in a major Latin American city and treats it as a function of cultural differences and the availability of alternative options for medical care. Press compared two groups of clients: at a hospital ambulatory clinic and at an office of a curandero. The two groups were similar in age, gender, education, and occupation. Both groups of clients were similar in their beliefs concerning the cause of illness but appeared to adjust their presenting complaints to the setting they were in. Press found that "dual use" was most common among the least acculturated and the low socioeconomic group. However, he makes the point that people in the higher socioeconomic groups engage in dual use as well, involving private medical practitioners and "quasi-medical" and traditional curers. Press suggests that the

pattern of dual use varies according to the acculturation process. That is, this pattern is more common for the least acculturated. However, this claim is weakened as he confounds acculturation and socioeconomic status.

Press concludes with an interesting suggestion about dual use in urban areas. He argues that curanderismo serves a psycho-social need that is peculiar to urban life and speculates that the availability of alternative options is a growing phenomenon in cities. He provides evidence that suggests that there is support for traditional healing forms in urban areas which is contrary to what is usually found in the literature. In a later article,[26] Press expands conceptually on the psychosocial functions of what he calls urban folk medicine. These practices serve such functions as the maintenance of cultural identity, acculturation, and coping with failure. We will return to these ideas below.

This chapter has provided the background for a cultural theory of dual utilization with an emphasis on the cultural differences between Third World groups and the health care system. It has also reviewed literature that studies the role of predisposing factors, i.e. age, gender, race, and education, in patterns of utilization. Based on the research summarized in this chapter, it is possible to identify several problems that highlight the importance of this dissertation. First, the relationship

of chronic disease to health-related behavior. This is important because the type of dependency created by chronic illness can legitimately be said to magnify the influences of culture. Second, the emphasis on quantitative differences in utilization behavior, i.e. volume of utilization, tends to reinforce the assumption that alternatives to professional scientific medicine are not "normal," and are "deviant" and, therefore, need not be studied as patterns but only as departures from rational procedure. Third, source of care has not been defined across a large enough range of options to account for the phenomenon of dual utilization or other possible variations. Fourth, there is inadequate definition of strictly cultural factors even in research that acknowledges their significance.

As far as the utilization patterns of Third World groups is concerned, this chapter briefly discussed the approaches that have been taken to explain these patterns. The present study emphasizes the impact of cultural differences between Third World groups and the health care system on utilization patterns. It must nevertheless be recognized that in the background are the structured inequalities of the health care system as well as those of the larger society. Furthermore, it is reasonable to argue that the culture of scientific medicine reflects the norms of the larger culture in which it is situated and to that extent embodies the invidious distinctions and

structured inequalities of the dominant culture. This aspect of the cultural approach to utilization is part of the field research associated with this project and will not be discussed as such in the dissertation. As far as the "culture of poverty" is concerned we see this as both a misuse of the culture concept and an instance of blaming the victim[27] which is a reflection of institutional racism and other structural inequalities in our society. Studies in the health field that take this approach often conclude that the poor are incapable of making use of any health care system due to lack of experience and knowledge, thereby, begging the cultural questions and the issue of the rationality of choice.

There is a wide range of beliefs about health and illness in our society which vary in the extent to which they are congruent with the beliefs of scientific medicine. These cultural beliefs are largely derived from ethnic group membership. There is evidence that suggests that these cultural differnces are manifested in different attitudes toward health and illness and behavioral differences in response to illness. It is reasonable to assume that if there are different behavioral responses to symptoms and pain there are going to be different behavioral responses in relation to whether, where, and how to seek care. It has been suggested that age, education, and generation may affect the influence that cultural

factors have on health-related behavior.

Saunders sheds considerable light on cultural differences with regard to health and healing, independent of the ethnocentric bias of normative theory without begging the question of the relationship of culture to sociology, and without assuming that departures from scientific medicine are irrational. That is, he does not place one healing system above another in terms of value, rather he explores the differences from an analytic approach that allows for alternatives. Saunders' work has not been given the prominence it should have received. It may have been that the political climate of the era in which his book was published was not receptive to his ideas. Also, the ethnographic approach may have seemed less objective than the quantitiative analysis favored in sociology. His work may be more provocative today because of a greater acceptance of field research and a political environment that is more sensitive to the claims of cultures that are not dominant. Saunders' work offers hypotheses of particular interest in the area of cultural differences.

Chronic illness requires an ongoing relationship involving unfamiliar degrees of dependencies between the client and practitioners in the health care system. Contact with physicians and other health professionals are unlike those for acute episodes of illness which have a

defined duration and seem less global in impact on total personality. This suggests that cultural background will play a more prominent part in encounters having to do with chronic illness than those in which illness is acute.

The above considerations suggest the following hypothesis. In the case of chronic illness where there are culturally significant background differences, utilization patterns will depend on extra-medical considerations, that is, cultural considerations for both the practitioner and the client.

NOTES

[1]Ronald Andersen, A Behavioral Model of Families' Use of Health Services, research series, no. 25, Center for Health Administration Studies, (Chicago: University of Chicago Press, 1968); Ronald Andersen, Bjorn Smedby, and Odin W. Anderson, Medical Care Use in Sweden and the United States: A Comparative Analysis of Systems and Behavior, research series no. 27, Center for Health Administration Studies, (Chicago: University of Chicago Press, 1970); and Ronald Andersen and John F. Newman, "Societal and Individual Determinants of Medical Care Utilization in the United States," Milbank Memorial Fund Quarterly 51 (Winter, 1973):95-124.

[2]Cheryl Maurana, Robert L. Eichhorn, and Lynne E. Lonnquist, The Use of Health Services: Indices and Correlates, National Center for Health Services Research, (1981).

[3]Lu Ann Aday and Ronald Andersen, Development of Indices of Access to Medical Care (Ann Arbor: Health Administration Press, 1975); Lu Ann Aday, Ronald Andersen, and G.V. Fleming, Health Care in the United States, Equitable for Whom?(Beverly Hills, CA: Sage Publications, 1980); A.C. Marcus et. al., "Monitoring Health Status, Access to Health Care, and Compliance Behavior in a Large Urban Community: A Report from the Los Angeles Health Survey," Medical Care 18 (1980):253-65; Cheryl Maurana and Robert L. Eichhorn, The Use of Needed Physician Services: An Analysis of Seventeen Health Surveys (West Lafayette, IN: Health Services Research and Training Program, 1977); and D.G. Taylor, Lu Ann Aday, and Ronald Andersen, "A Social Indicator to Access of Medical Care," Journal of Health and Social Behavior 16 (1975):39-49.

[4]e.g., Bonnie Bullough, "Poverty, Ethnic Identity, and Preventive Health Care," Journal of Health and Social Behavior 13 (1972):347-59; Lu Ann Aday, "Economic and Non-economic Barriers to the Use of Needed Medical Services," Medical Care 13 (1975):447-56.

[5]See David Sudnow, Passing On: The Social Organization of Dying (Englewood Cliffs, NJ: Prentice-Hall, Inc., 1967) for a case study of the formation and maintenance of professionals' attitudes toward certain aspects of illness in a public hospital.

[6]The tendency to judge other cultures by the stand-

ards of one's own group and, therefore, to believe that one's own group is superior.

[7]c.f. Charles L. Sanders, Black Professionals' Perceptions of Institutional Racism in Health and Welfare Organizations (Fairlawn, NJ: R.E. Burdick, Inc., 1972).

[8]Oscar Lewis, La Vida (New York: Random House, 1966).

[9]e.g., Charles A. Valentine, Culture and Poverty: Critique and Counter-Proposals (Chicago: University of Chicago, 1968); Eleanor Leacock, ed., The Culture of Poverty: A Critique (New York: Simon and Shuster, 1971).

[10]e.g., John M. Goering and Rodney M. Coe, "Cultural Versus Situational Explanations of the Medical Behavior of the Poor," Social Science Quarterly (1970):309-19.

[11]e.g., Marshall H. Becker, ed., The Health Belief Model and Personal Health Behavior Health Education Monographs. Society for Public Health Education, Inc. 2 (1974):324-511.

[12]Mark Zborowski, "Cultural Components in Responses to Pain," Journal of Social Issues 8 (1952):16-30.

[13]Although Saunders acknowledges the awkwardness of this terminology, he decides to use it to indicate that there are several groups referred to by this term, e.g., "Spanish-American," "Mexican-American," and "Mexican." See pp. 44-63.

[14]Saunders, p. 7.

[15]Edward A. Suchman, "Sociomedical Variations Among Ethnic Groups," American Journal of Sociology 70 (November, 1964):319-31.

[16]The behavior variable does not refer to utilization behavior, but rather to response to illness, i.e., acceptance or dependence.

[17]Suchman, p. 325.

[18]Goering and Coe, pp. 309-10.

[19]Reed Geertsen et. al., "A Re-examination of Suchman's Views on Social Factors in Health Care Utilization," Journal of Health and Social Behavior 16 (June, 1975): 226-37.

[20]Emil Berkanovic and Leo G. Reeder, "Ethnic, Economic, and Social Psychological Factors in the Source of Medical Care," Social Problems 21 (1973):246-59.

[21]Ibid., p. 255.

[22]Eliot Freidson, "Client Control and Medical Practice," American Journal of Sociology 65 (January, 1960): 374-82.

[23]Ibid., p. 377.

[24]Julian Roebuck and Robert Quan, "Health-Care Practices in the American Deep South," in Mariginal Medicine, ed. by R. Walles and P. Morely (New York: Free Press, 1976), pp. 141-61.

[25]Irwin Press, "Urban Illness: Physicians, Curers, and Dual Use in Bogota," Journal of Health and Social Behavior 10 (September, 1969):209-18.

[26]Irwin Press, "Urban Folk Medicine: A Functional Overview," American Anthropologist 80 (1978):71-84.

[27]William Ryan, Blaming the Victim (New York: Vintage Books, 1976).

Chapter Three: THE RESEARCH PROBLEM AND METHODOLOGY

The purpose of this research is to show that the utilization of healing resources represents a significant moral choice for certain types of client. This choice can present them with a conflict that can only be resolved by accepting or rejecting significant culturally based self-related meanings and values. People are socialized into a culturally organized healing environment that includes healing practices and obligations. Thus, it is reasonable to assume that healing orientation reflects the imperatives of its cultural origin, that it is relatively articulated in a system of beliefs, and that practices correspond to this belief system. Therefore, measures of healing orientation, belief, and health practice relate to the client's participation in his or her culture.

On the other hand, the influence of the culture to which a person is socialized is mediated to some extent by the dominant culture to which they are subjected or in which they also participate. Therefore, any utilization choice resolves a conflict for the individual between cultural imperatives and other rationalizations of experience that seem to be culturally alien.

A major concern in this study is the behavior of persons who are ill as it relates to utilization choices

by members of Third World ethnic groups. The utilization decisions people make generally depend on the way in which they relate the imperatives of their culture to their experience with illness and on the practical options available and/or accessible to them some of which may be either at odds with or unrelated to their culture. We can assume (1) that people make utilization choices that are consistent with the cultural imperatives to which they are socialized, and (2) that these choices are modified by practices that are represented as rational to the solution of problems associated with illness but lack, so far as the client is concerned, cultural substantiation.

Our working hypothesis is that beliefs about health and healing express the individual's involvement in and subordination to his or her culture more than individualized attributes such as education, socioeconomic status, or severity of illness. Ethnographic evidence suggests that health-related beliefs and behavior are systematically connected with general culturally-based experiences of well- or ill-being. At the same time, some behaviors are more likely to express the individual's cultural orientation than others. In particular, there is a difference between the choice of healing agents and the choice of remedies or treatments. Since in traditional cultures knowledge about the body and healing is shared by all members of the culture and is resistant to conscious re-

flection and criticism, the choice of remedies should be a stronger expression of culture than the choice of healers. The person who uses a traditional healer makes a more deliberate choice in their practices concerning health. This study examines the relationship of beliefs about the relative efficacy of scientific and traditional healing to utilization patterns involving choice of remedy and choice of healing agent, and the extent to which this relationship depends upon cultural orientation rather than strictly instrumental rationalizations of health-related behavior and individual experience.

It is our contention that dual utilization is an attempt to resolve the conflict implicit in the medical encounter between indigenous cultural imperatives and rationalistic expectations of a dominant, and perhaps alien culture. The pattern of dual utilization may be manifested in different ways. It can take the form of serial utilization, in which healing systems are used one at a time in sequence with either the traditional system or scientific medicine being used initially. Dual utilization may also be simultaneous. In this case, both systems are used at the same time. Whichever pattern emerges may be due in part to the nature of the individual's health problem but it is an accepted strategy that has evolved within the cultural group to which the individual belongs.

In order to explore dual utilization, it was decided to look at a client population already using scientific medicine in a clinic with which the author had a research affiliation.

Setting

Four medical facilities located in Brooklyn, New York were selected for study: Downstate Medical Center, Kings County Hospital Center, Brooklyn Hospital, and the Sunset Park Family Health Center at Lutheran Medical Center. Each facility provides ambulatory care which includes a rheumatology clinic that meets at least once a week. Downstate Medical Center is affiliated with the other institutions. This involves the exchange of medical students and staff. It is this affiliation that gave us the initial contacts with the other ambulatory care departments.

The borough of Brooklyn has a population of 2.6 million people. If it were incorporated as an independent municipality, it would rank as the fourth largest city in the United States. Brooklyn is a borough that provides for its inhabitants organic complexity, the typical density of urban living, and a sense of community. The latter depends upon the existence of neighborhoods with a variety of culturally solid ethnic groups. Since Brooklyn's merger with New York City in 1898 there have

been massive waves of immigrants into the borough. Earlier waves of immigrants included Germans, Irish, Italians, Scandinavians, Jews, and Slavs. Later, there was an inmigration of blacks from the South. More recently there have been increases in populations from the West Indies and the Caribbean and further increases in the number of American blacks.

Brooklyn Hospital is the oldest and was the first voluntary hospital in Brooklyn. It has served the Fort Greene, Brooklyn Heights, downtown Brooklyn, and Flatbush communities. However, in recent years Brooklyn Hospital has drawn clients from other sections of the borough as well. Many local hospitals serving low-income areas have been forced by financial difficulties to close down. Consequently, residents of those areas have had to seek medical care in other, outlying hospitals.[1] In 1982, Brooklyn Hospital merged with Caledonian Hospital to form a new corporation, The Brooklyn Hospital-Caledonian Hospital.[2] Together they continue to serve both hospitalized and ambulatory clients from areas far beyond those originally serviced by each hospital.[3]

In 1980, there was a total of 44,866 ambulatory care visits at Brooklyn Hospital including visits to the medical clinic and subspecialty clinics.[4] The catchment area includes Fort Greene, downtown Brooklyn, and Brooklyn Heights. Clients living in the catchment area pay

their fees on a sliding scale. Those clients living outside the catchment area pay a flat fee with extra charges for services such as x-rays. Fifty percent use Medicare, fiver percent use Blue Cross, and twenty five percent are self-paying.[5]

Kings County Hospital Center is the largest municipal hospital in New York City and one of the largest in the country. In the fiscal year 1982, Kings County had a total of 868,076 ambulatory visits.[6] The ambulatory services department at Kings County Hospital Center includes a medical clinic and several specialty and subspecialty clinics with a wide variety of services provided.[7] The primary catchment area includes East Flatbush, Brownsville, and East New York. Clients who live in the catchment area pay their fees on a sliding scale. In general, thirty-three percent of the client population use Medicaid, six percent use Medicare, and sixty-one percent are self-paying. These figures vary according to clinic, e.g., for the medical clinic thirty-five percent use Medicaid, twenty-five percent use Medicare, and forty percent are self-paying.

The Lutheran Medical Center ambulatory care department consists of two sections: the Sunset Park Family Health Center and the Specialty Clinics. The Family Health Center opened in 1967 to implement an Office of Economic Opportunity (OEO) grant for ". . . comprehensive family

based care for the medically underprivileged."[8] The specialty clinics provide the usual specialty services such as cardiology, endocrinology, hematology, and rheumatology, etc. Together, these two sections function as an integrated whole to provide comprehensive, family based diagnostic, therapeutic, preventive, and educational services.[9]

According to the Director of Ambulatory Care, the neighborhood immediately surrounding Lutheran Medical Center contains very few, if any, mainstream sources of medical care. In addition, the transportation in this area is not adequate, and this contributes to the difficulty of obtaining medical services. One of the obvious implications of this situation is the dependency of the neighborhood population on this facility. In 1967, Lutheran Medical Center received three-quarters of a million dollars from OEO for a neighborhood-based health center. As a result of this grant, on October 2, 1967, the Family Health Center opened. At that time it had a minimal staff and budget with which to operate. Today it operates on a 10.5 million dollar budget for the ambulatory care department only. It lists approximately 38,000 clients, but, according to the Director, people borrow other people's cards and go under more than one name in order to be eligible for lower fees. Therefore, the official estimate of numbers may be slightly exaggerated. The health center is limited to a catchment area which includes Sunset Park,

the immediately surrounding neighborhood, and Bay Ridge. The people living in this area pay fees on a sliding scale. The few people living outside the area who come here have to pay a $25 fee plus any medication, x-rays, etc. Forty-five percent of the clients have Medicaid, private insuramce covers less than ten percent of the clients, and some have Medicare. The health center, with forty-three employees and fifty to sixty physicians on staff, is open during the day and evening hours.[10]

Downstate Medical Center is part of the State University system of New York and as such varies in certain respects from the other institutions. Downstate offers clinics only in specialty and subspecialty areas. As a result, a small proportion of their client population comes from all areas of Brooklyn as well as outside of the borough. The major portion of the clients, however, are from the neighborhoods immediately surrounding the medical center: Crown Heights, East Flatbush, Flatbush, Prospect-Lefferts Gardens, and Brownsville. In 1984, there were a total of 55,000 client visits made to the ambulatory clinics. Of these, thirty percent used Medicaid, thirty percent used Medicare, and forty percent were self-paying. Those who use self-payment pay fees on a sliding scale between $14 and $90 depending on family size and income.[10]

Arrangements for the Present Study

Field Research:

The rheumatology clinic at Downstate Medical Center was easily accessible since it is in the ambulatory care department of the institution under whose auspices this research was conducted. In addition, the Director of the clinic was the Principal Investigator of the Multipurpose Arthritis Center. However, since the author lacked an initial formal introduction to clinic staff members, she ultimately ran into come difficulties during the course of the field work. Some staff members came to know the author quite well whereas others never really quite knew who the author was or her purpose for being there.

At Lutheran Medical Center access was initially gained by contacting the Director of Ambulatory Services by telephone. After reviewing the author's curriculum viae and the research proposal for the study, the Director conducted a legthy interview with her. During the course of the interview permission was granted and strategies were discussed. The author was given a formal orientation to ambulatory services which lasted an entire day. This orientation was the same one that physicians receive who are new to the staff of Lutheran Medical Center. In order to avoid any confusion in the clinics as to who she was, the author was given a white coat to wear. Thus, entry into the system and the field work were facilitated

by this movement through channels. The white coat, in particular, gave the author an official presence she would not ordinarily have had and the orientation provided a "map" and helpful contacts with staff members.

At Brooklyn Hospital access was gained by virtue of the fact that the Chief of Rheumatology was Project Director of the Multipurpose Arthritis Center and was kind enough to allow easy access to the rheumatology clinic. The fact that this clinic is quite small further eased the problem of access.

Kings County Hospital Center is closely affiliated with Downstate Medical Center. Thus, access was easily gained through an arrangement made by the Director of the rheumatology clinic at Downstate Medical Center and the Director of the rheumatology clinic at Kings County Hospital Center. By and large, most of the time in the field was spent at Downstate Medical Center and Lutheran Medical Center.

The Survey:

It was necessary to make a formal application in order to obtain permission to conduct a survey in the rheumatology clinic at Downstate Medical Center. This procedure involved preparing an application to the Health Science Review Committee on Investigations Involving Human Subjects at Downstate Medical Center. Approval was

ultimately granted by the committee. This later turned out to be a prerequisite for application to the Health and Hospitals Corporation to gain access to the Kings County Hospital Center. Application was made to the Health and Hospitals Corporation and permission was granted to conduct our survey at Kings County Hospital Center.

The procedure was different at the remaining two research sites. At Lutheran Medical Center, permission to conduct this survey was granted since another survey from the Multipurpose Arthritis Center had been conducted there which the author had helped coordinate just prior to the present study. At Brooklyn Hospital, access to conduct a survey was arranged through the Project Director of the Multipurpose Arthritis Center who was mentioned earlier.

The clients who were approached to participate in the study were each given a brief description of the objectives of the study. They were assured that their responses would be confidential and that we were solely interested in their own opinions and experiences, not in responses that could be judged correct or incorrect.

Clients at Downstate Medical Center and Kings County Hospital Center were asked to sign a consent form agreeing to participate in the study, as required by these two institutions. Although responses were to be confidential,

the fact that people had to sign their names on consent forms placed a limitation on the type of data gathered. The intention of the original study design was to exclude respondents' names. The reason was that it was felt that personal information would have to be revealed to interviewers during the course of the interview. Another consideration was that it was possible that the names of people who are undocumented with regard to their immigrant status would be selected to be interviewed. To have asked for names in those cases might have discouraged them from participating in the study. Assurances of complete confidentiality would allow subjects to feel free to give more and private information than they would under other conditions. When it was first learned that consent forms would be necessary initials were suggested as sufficient. However, this idea was not acceptable to the committee involved in making the decision. We do not know if, or to what extent, the introduction of the consent form had an effect on sampling or on people's responses. The issue of confidentiality also may have had an effect on the rapport between interviewer and respondent and the possibility that subjects may have been reluctant to discuss sensitive and/or private matters.

Methods of Sampling

Trained interviewers were in attendance at each

rheumatology clinic session at the four research sites. Downstate Medical Center and Kings County Hospital Center clinics meet twice a week and Lutheran Medical Center and Brooklyn Hospital clinics meet once a week. The appointment rosters for the day were made available to the interviewers at each clinic meeting. From these rosters, clients were selected according to the following sampling procedures. At Downstate, every fifth client was selected, at Kings County, every other person was selected, at Lutheran and Brooklyn all the clients were interviewed because of the small number involved. After two weeks of this type of sampling which produced thirty-two cases, a different sampling strategy was adopted to insure the inclusion of more men at all the clinics[12] and more Latino clients at Downstate and Kings County where Latinos do not enter in as large numbers as other groups. These sampling goals were pursued until interviewing was completed. In the background were many problems. Clinic settings are not always conducive to conducting interviews. While sampling rules were established, under certain conditions exceptions were made. In designing this aspect of the study, it was thought that there would be little or no difficulty in making use of normal waiting time for clients to conduct interviews. This assumption did not always turn out to be correct. Clients' waiting time was not always idle: they would be called for differ-

ent purposes, e.g., lab tests, nurse consultations, physician consultations, and medications. As a result, there were difficulties in interviewing the appropriate clients, and even in the midst of an interview a client might be called away. In the larger clinics it was less difficult to maintain the sampling method described above. In the smaller clinics, interviews were held with clients who were available, always bearing in mind the original sampling goals.

When interviews were interrupted every effort was made to wait for the client (with his or her permission) in order to resume and complete the interview. Most clients cooperated. Some did not return or returned only to inform the interviewer that they finished for the day and were leaving. At this point, every effort was made to complete the interview at another clinic session, or on occasion over the phone. Usually, interviews could be completed at another clinic session. This procedure was followed in approximately twelve cases, two were completed by phone, and three remained incomplete. When clients new to the clinic were selected, the interviewers were instructed to conduct interviews after the person had seen a physician. The few items that were inappropriate for first time clients were dropped out of the anlysis.

Client Interviews

Interviews were structured in the form of a questionnaire which contained a few open-ended questions but mostly fixed-choice questions. Interviewers were instructed to probe at various points throughout the interview. Interviews lasted approximately forty minutes and included such topics as health beliefs, expectations, attitudes, ethnicity, perception of health care providers, and utilization. The questionnaires were administered in both English and Spanish by trained interviewers who were in most cases matched to the respondents on the basis of ethnicity. (See below: "Interviewers")

Spanish Translation

Since a large number of people using the clinics we were studying are Spanish speaking, all materials were translated into Spanish. The procedure was, first, to have the questionnaire and consent form translated into Spanish by a native Spanish speaking sociologist of Puerto Rican background and then to have it translated back into English by another native speaker, a sociology student of Cuban background. The reason people with these ethnic backgrounds were selected to do translation was that a large number of the Spanish speaking respondents were Puerto Rican and all were from the Caribbean area. Finally, the translators met together with the author (who

has a working knowledge of Spanish) in order to resolve any outstanding discrepancies. For the translation of the more comples rheumatic diagnoses, the author consulted with two native Spanish speaking rheumatologists.

Interviewers

Interviewers were recruited from a population of mostly graduate students of black or Latino background. A formal training session for interviewers was held in which the entire questionnaire and the sampling procedures were explained and reviewed in detail. This session was followed up by weekly meetings during the entire time interviewing was going on in order to monitor the progress of the interviewers as well as to handle any questions or problems that may have come up. A by-product of these meetings was that they provided forums for the interviewers to discuss unanticipated problems and potentially significant but unexpected experiences of respondents.

An effort was made to match the ethnicity of the interviewer with that of the respondent. Two of the interviewers conducting interviews in Spanish were not Latino themselves but were familiar with Latino cultures through family connections. The matching of the ethnicity of the interviewers with that of the respondents was seen as crucial for achieving good rapport with respondents.[13] Also, given the nature of some of the questions being asked,

particularly those related to traditional beliefs and practices, it was felt that respondents would more likely be honest and more comfortable with someone who shares their culture and who may possibly have personal knowledge and experience congruent with the respondents' knowledge and experience. There were, however, class differences among the interviewers. In the future it may be possible to compare the data by interviewer. Another problem that had to be considered was that the client might perceive the interviewer as having an official connection with the hospital. We tried to address this problem by a careful wording of the introductory statement to the clients.

Procedure

Clients that were selected to be interviewed were approached in the waiting areas of the clinics. In three out of the four clinics a staff person (usually a nurse) would call out the name of the client to be interviewed. At the fourth clinic, the interviewers called the clients. In all cases it was up to the interviewers to explain what they were doing there. On the one hand, it was felt that a nurse initiating contact would give the interviewers more credibility. On the other hand, there was the danger of suggesting an official connection of the interviewer to the hospital. The procedure that was adopted was for the interviewer to explain to the respondent who he or

she was and the purpose of the study.

Interviews were conducted in separate rooms whenever space allowed unless the designated room was pre-empted by a physician or a meeting. Otherwise they were conducted in empty corridors available for use or, barring that, empty corners of the waiting room.

Pilot Study

Before embarking on the client survey the survey instrument was tested in a pilot study. All the interviewers (including the author) attended one of the clinic sessions where each interviewer interviewed two clients. Interviews were conducted in both English and Spanish. The clients interviewed for the pilot study were not included in the sample of the actual study. As a result of the pre-test, some questions were completely eliminated or shortened and the order of some questions was changed to allow the interview to flow more smoothly. For a few of the questions the range of possible responses was expanded.

Sample Description

In order to provide a background to the study this section includes a profile of the sample. Tables 1 through 6 show the distribution of respondents by clinic, age, gender, education, income, and ethnicity.

Table 1: CLINIC DISTRIBUTION

	Number	Per cent of Total N
Downstate Medical Center	113	47
Kings County Hospital Center	59	24
Lutheran Medical Center	36	15
Brooklyn Hospital	34	14
Total N	242	100

Table 2: GENDER DISTRIBUTION

Gender	Number	Percent
Women	182	75
Men	58	25
Total N	242	100

Table 3: AGE DISTRIBUTION[14]

Age	Number	Percent
Young (39 and below)	45	19
Middle (40-59)	119	50
Aged (60+)	75	31
Total N	239*	100

*There were missing data for three persons.

Table 4: LEVEL OF EDUCATION[15]

Education	Number	Percent
Some HS or less	153	66
High School graduate	61	26
College +	18	8
Total N	236*	100

* There were missing data for ten persons.

Table 5: INCOME LEVEL*[16]

Income	Number	Percent
$5,999 and below	97	46
$6,000-11,999	78	37
$12,000+	36	17
Total N	211**	100

*Income refers to family income.
**There were missing data for thirty-one persons.

Table 6: ETHNIC GROUPS

Ethnicity	Number	Percent
American black	91	38
West Indian black	36	15
Puerto Rican	76	32
Others	37	15
Total N	240*	100

*There were missing data for two persons.

In order to arrive at "ethnicity," we categorized people according to the folowing scheme based on cultural considerations: American blacks, West Indian blacks, Puerto Ricans, and others. The "other" category contains Latinos other than Puerto Ricans, Asians, and a native American. People were assigned to these categories on the basis of how they responded to two items on the questionnaire. First, they were asked to identify themselves as part of an ethnic group. Second, they were asked where they were born.[17] So that, for example, if someone responded "black" to the first item and "United States" to the second, they were assigned to the American black category.

Since the sample had been selected from rheumatology clinics, it was assumed that everyone had received a diagnosis of arthritis or a related rheumatic disease. Table 7 shows the distribution of diagnoses in the sample based on self-report.[18]

Table 7: Diagnoses

Diagnosis	Number	Percent
Rheumatoid Arthritis	78	33
Arthritis/Rheumatism	88	38
Multiple System Disease	48	20
Other	25	10
Total N	239*	101

*There were missing data for three persons.

The arthritis/rheumatism category refers to osteoarthritis (21), arthritis (60), and rheumatism (7). Multiple system disease refers to systemic lupus erythematosus (27), psoriatic arthritis (1), gout (12), ankylosing spondylitis (1), Reiter's syndrome (1), bursitis (3), and scleroderma(3). The "other" category consists of persons who said they did not receive a diagnosis, who were not sure of the diagnosis, or did not know what their diagnosis was.

The illness variable was defined as perceived severity of illness. Perceived seriousness was measured by creating a new variable from two items on the questionnaire concerning severity of original symptoms and present symptoms.[19] The strategy that was used to create the new variable of perceived severity can be seen in Chart 1. The new categories created were A - mild, B - moderate, and C - severe. If a person reported original symptoms

Chart 1: PERCEIVED SEVERITY OF ILLNESS

	Present Symptoms			
Original symptoms	a lot better	somewhat better	same	worse
mild	A	A	A	B
moderate	A	A	B	C
severe	B	B	C	C

that were either mild or moderate and reported that present symptoms were a lot better or somewhat better, this was considered mild. For people who reported original symptoms as mild and reported present symptoms as the same, it remained mild; if it was reported as worse, it was considered moderate. If a person reported original symptoms as moserate and present symptoms as the same, this was considered moderate; if present symptoms were reported as severe, it was considered severe. If original symptoms were reported as severe and present symptoms a lot better or somewhat better, this was considered moderate; if present symptoms were reported as the same or worse, this was considered severe. The results were that twenty-seven percent fell into the mild category, fifty-one percent in the moderated category, and twenty-two percent in the severe category.[20]

As can be seen from the above tables, the people in the sample who are mostly from Downstate Medical Center and Kings County Hospital Center, are mostly women, middle-aged or older, are not high school graduates, are low-income, and are either American black or Puerto Rican. They reported diagnoses for their conditions as mostly rheumatoid arthritis or "arthritis" which most likely includes rheumatoid arthritis and osteoarthritis.

Utilization

Based on responses to the questionnaire, we were able to establish that a portion of the sample had used traditional healers, traditional remedies, or both. Altogether, four measures were used for the utilization variable: (1) use of healers, (2) use of remedies, (3) use of a combination of healers and remedies, and (4) a comparison between physicians and traditional healers. The fourth measure was used for validation purposes. The list of healers[21] that was provided for respondents to choose from was based on the literature and field work and represents a range from scientific to traditional approaches to health care. Two categories of utilization were derived from responses to this item: "single utilization and "dual utilization." The first category consists of people who reported the use of scientific healing agents. The second category consists of people who utilized at least one of the healers on the list that were categorized as the most traditional: spiritualist, herbalist, fortune teller, root doctor, santero(a), advisor, old lady, faith healer, and person in botanica.

We found that twenty-five percent of the sample had used traditional healers as well as physicians - dual utilization?[22] We asked about general utilization, i.e., utilization for all conditions since we felt people would be more willing to admit use than if we asked about

specific conditions. People are hesitant to admit that they use traditional healers and remedies since these are not sanctioned by the culture of scientific medicine and are considered backward and "primitive." Press reports the same difficulty: ". . . few clinic patients admitted to having ever attended a curandero, either in the city or campo let alone for the present complaint."[23] For the utilization of healing practices we followed a similar procedure. The list,[24] again, included remedies ranging from scientific to those that would be considered traditional based on the literature and field work. Remedies were divided into two categories: "single utilization" and "dual utilization." Based on a strict assignment of responses, we used only two items from the list to indicate use of traditional remedies for the dual utilization category: herbs and seance. A person who used at least one of the traditional remedies was assigned to the dual utilization category. We decided on thses categories in order to draw a sharper boundary between scientific and traditional remedies. We found that twenty-three percent of the sample had used one or both of these traditional remedies.

A third measure of utilization was created by combining the previous two measures into an index of total utilization. A four-point scale was created ranging from scientific on both healers and remedies (score - 1) to

to traditional on both healers and remedies (score - 4). See Chart 2 for these categories. Based on these scores respondents were divided into two groups: (1) single utilization and (2) dual utilization. Table 8 shows the range of scores and the distribution in the sample. Those who had a score of 1 were put into the single category and those who had a score ranging from 2-4 were placed in the dual category. Thus, thirty-six percent of the sample fell into the dual utilization category.

Chart 2: UTILIZATION INDEX

Healers	Remedies	Utilization
Scientific	Scientific	Single
Scientific	Traditional	Dual
Traditional	Scientific	Dual
Traditional	Traditional	Dual

Table 8: UTILIZATION INDEX SCORES

Score	Percent of Total
1	64
2	12
3	13
4	11

Finally, a fourth measure of utilization was derived from choice of healing agents as an indirect measure to test the validity of the direct measure.[25] In going through each item people either answered the question as it was presented or voluntarily said that they had not been to another healer. The responses were consistent throughout this item. That is, there were the same number of people on each item that answered the specific question or said they had not been to any other healer. Thiry-four percent of the sample reported that they had been to healers other than physicians.

As can be seen from these findings, there is a pattern of dual utilization for both healing agents and practices. A sizeable percentage of clients already committed to the use of treatment plans sanctioned by scientific medicine also pursue other healers and remedies. Having established dual utilization in a clinic population where it may not have been expected, it was necessary to explain these findings. The following hypotheses are proposed within the cultural model described in chapters one and two. Adherence to traditional culturally-grounded health beliefs is likely to lead to a utilization pattern that includes culturally sanctioned behavior. As was indicated in the previous chapter, other studies have found or have suggested that age, gender, education, generation, and perceived need, i.e., health status, influence util-

ization or have an impact on the influence of culture on a person's health-related behavior. But, if culturally-grounded beliefs are decisive in utilization, then this relationship should be relatively independent of non-cultural individual characteristics such as education and perceived severity of illness. On the other hand, if utilization involves a choice from among alternatives that are culturally sanctioned, it shoud reflect differences in individually experienced aspects of culture, in particular gender, age, and generation: gender because women are thought more involved in the reproduction of culture, age because very young and old people are thought less critical of acquired culture, and generation becuase first generation members of a migrant community have relatively less contact with the dominant culture.

Health Beliefs

The independent variable, "health belief," is considered to be culturally-grounded. This is substantiated by a fair degree of agreement in the literature that healing is a culturally expressive sphere of conduct and belief.[26] Furthermore, because such spheres are reinforced through the socialization of children, it is reasonable to assume that all members retain the dispositions involved in culturally sanctioned healing even where they are unable or unwilling to articulate the corresponding be-

liefs. The index of culturally-established beliefs was created from a series of health belief items from the questionnaire.[27] Items were selected that seemed most indicative of a grounding in traditional culture.[28] The scores from these items were collapsed into a two-point scale indicating degree of adherence to traditional health beliefs. A low degree of adherence was scored 1 and a high degree of adherence was scored 2. Thus, a 4 represents low or no adherence and an 8 indicates the greatest degree of adherence. Table 9 shows the range and distribution of scores in the sample. The sample was divided between 5 and 6 since a 6 meant at least fifty percent adherences to traditional health beliefs. The first group, those with the greatest adherence to traditional beliefs, had scores in the range of 6-8 representing twenty-two percent of the total sample. The second group, those whose adherence is low or non-existent had scores of 4 and 5 representing seventy-four percent of the total sample.

Table 9: HEALTH BELIEF INDEX SCORES*

Score	Percent of Total N
4	55
5	19
6	9
7	8
8	5

*Missing data required eliminating people from the index.

The next step was to see whether beliefs were independent of social background variables, since hyptheses about the consistency of beliefs and practices require controlling for those factors as independent evidence of culture. Table 10 shows that beliefs are relatively independent of gender, age, and education. Contrary to what may have been expected regarding the influence of education (or sophistication) on traditional beliefs, it is interesting to note the percentage of people in the highest category of education who adhere to culturally-established health beliefs. This result, though, is based on small numbers.

Having established the relative independence of health beliefs and the pattern of dual utilization it is now possible to test the hypotheses about the relationship between beliefs and practices. Tabular analysis was used with tests of significance based on chi-square. The results are reported on and discussed in the next chapter.

Table 10: HEALTH BELIEFS AND SOCIAL BACKGROUND

	Social Background								
	Gender		Age			Education		
Health Beliefs	Men (%)	Women (%)	Young (%)	Middle-aged (%)	Aged (%)	Low (%)	Medium (%)	High (%)
Scientific	71	78	78	76	78	74	87	67
Traditional	29	22	22	24	22	26	13	33
Total	100	100	100	100	100	100	100	100
n	(56)	(179)	(45)	(119)	(71)	(153)	(61)	(8)
chi-square	1.09		.13			5.25		
p	.30		.94			.07		

NOTES

[1]Brooklyn Hospital, Annual Report, 1979 and 1980.

[2]Brooklyn Hospital, Press Release, October 1, 1982.

[3]Brooklyn Hospital, Annual Report, 1980.

[4]Ibid.

[5]Interview with F. Weinstein, Billing Department, Brooklyn Hospital.

[6]Interview with Chuck Rogers, MD, Associate Director for Ambulatory Care at Kings County Hospital Center.

[7]Kings County Hospital Center Ambulatory Services Manual, May, 1982.

[8]Suzanne Howe, Manual for Family Health Center and Specialty Services (July, 1980).

[9]Ibid.

[10]Interview with Suzanne Howe, MD, Director of Ambulatory Care, Lutheran Medical Center.

[11]Interview with Martin Cziraky, Associate Administrator of Ambulatory Clinics at Downstate Medical Center.

[12]The clinic population is overly represented by women.

[13]Clemmont E. Vontress, "Racial Differences: Impediment to Rapport," Journal of Counseling Psychology 13 (1971):7-13.

[14]See item #61 in the Appendix.

[15]See item #60 in the Appendix.

[16]See item #76 in the Appendix.

[17]See items #5 and #8 in the Appendix.

[18]See item #3B in the Appendix.

[19]See items #2 and #4 in the Appendix.

[20]In a separate item concerning employment status, we found that thirty-nine percent of the sample is disabled. We decided, however, that perceived severity of illness was more interesting for our research problem.

[21]See item #53 in the Appendix.

[22]We suspect this represents an underreporting of the actual number of clients that use traditional healers. This point is taken up in the discussion of our results.

[23]Press, "Dual Use," p. 212.

[24]See item #54 in the Appendix.

[25]See item #55 in the Appendix.

[26]e.g., Saunders; Weidman; and Margaret Clark, Health in the Mexican-American Culture (Berkeley: University of California Press, 1969).

[27]See item #48 in the Appendix.

[28]See #48, parts A, C, F and G in the Appendix.

Chapter Four: THE ANALYSIS

Several general methodological criticisms can be made about this study. The sample is biased in favor of scientific medicine since it was drawn from a population that is already using the mainstream health care system. Had the sample been drawn from a different population base, for example a community-based population, it is reasonable to expect that the findings would have been strengthened. The size of the sample poses problems for the interpretation of statistics. This was unavoidable since, in a clinical setting, sampling is inevitably compromised by schedules and access conditions that are virtually impossible to control. The small number of cases occasionally produced problems of cells too small for statistical tests or interpretation. As a result, and in order to encourage further research, percentage differences and not only statistically significant relationships are discussed.

Health Beliefs

In the previous chapter we established that health beliefs are relatively independent of individual background or experience. This suggests, consistent with our fieldwork and the literature, that they are learned early in the

socialization process, and form part of the individual's character structure. An argument could be made in the opposite direction, namely that people first experience the utilization pattern and beliefs develop according to clients' experiences with different choices. Even if experience led to beliefs, the content in this case is traditional rather than idiosyncratic.

Health Beliefs and Utilization

According to the main hypothesis, which posits a positive relationship between health beliefs and utilization patterns, adherence to culturally established beliefs was expected to lead to a pattern of dual utilization. This relationship was also expected to be stronger for the choice of remedies than for the choice of healing agents. The choice of remedies should be a greater reflection of culture than the choice of healing agents since the former are socialized at an earlier age than the latter, and the latter are part of a more deliberative process of problem-solving than the former. Therefore, it is expected that choice of remedies will be more consistent with beliefs than choice of healing agents. The results are presented in Tables 1 through 3.

Table 1: HEALTH BELIEFS AND THE UTILIZATION OF HEALERS

	Health Beliefs	
	Scientific (%)	Traditional (%)
Healers		
Single	78	65
Dual	22	35
Total	100	100
n	(180)	(57)
chi square	4.17	
p	.04	

Table 2: HEALTH BELIEFS AND THE UTILIZATION OF REMEDIES

	Health Beliefs	
	Scientific (%)	Traditional (%)
Remedies		
Single	80	67
Dual	20	33
Total	100	100
n	(180)	(57)
chi-square	4.32	
p	.03	

Table 3: HEALTH BELIEFS AND THE UTILIZATION OF HEALERS AND REMEDIES

	Health Beliefs	
	Scientific (%)	Traditional (%)
Utilization		
Single	67	51
Dual	33	49
Total	100	100
n	(180)	(57)
chi-square	4.98	
p	.02	

Statistically significant relationships were found between health beliefs and patterns of utitilization. Those who adhere to traditional health beliefs are more likely to have a pattern of dual utilization for healers, remedies, and both together. The strongest relationship emerged for the use of a combination of healers and remedies. These results are consistent with the major hypothesis. They suggest that there is a cultural basis for the illness behavior of members of Third World ethnic groups who have a chronic illness. Therefore, the argument that a pattern of dual utilization represents a resolution of the conflict experienced by Third World clients between the culture of scientific medicine and the culture of their ethnic groups

is supported. The fact that dual utilization is found in an urban population is consistent with Press' findings. Press has suggested that the persistence of traditional healing practices in cities perform specific functions having to do with the maintenance of cultural and role identification, the minimizing of the trauma of acculturation, and providing psychotherapeutic-like supports for reducing stress.[1] The present study suggests that these functions are part of the expressive, self-reproductive aspects of culture and therefore operate as products of socialization independent of individual experiences with the problems of acculturation. The findings discussed below reinforce this conclusion.

Having established the relationships between health beliefs and utilization patterns, we are now in a position to critically test the remainder of our argument that holds that this relationship will be influenced by individually experienced aspects of culture, i.e., age, gender, and generation and will be independent of non-cultural individual characteristics, i.e., education and perceived severity of illness.

Age and Utilization

Age appears in the literature in terms of two possible influences on utilization. First, in the general

utilization literature, age has been found to predict volume of utilization. The trend is that older people are more likely than younger to use health services due to poorer health and the availability of Medicaid and Medicare. Second, the literature on the relation of cultural factors to health attitudes and behavior, suggests that older people have less contact with the dominant culture and therefore are more likely than young people to draw upon traditional beliefs about illness and treatment.

Age was controlled in order to evaluate its effect on the relationship between health beliefs and utilization. The results can be seen in Tables 4 through 6. It was

Table 4: HEALTH BELIEFS AND THE UTILIZATION OF HEALERS BY AGE

	Age Group					
	Young		Middle Aged		Aged	
	Health Beliefs*		Health Beliefs		Health Beliefs	
	S (%)	T (%)	S (%)	T (%)	S (%)	T (%)
Healers						
Single	77	70	77	58	82	68
Dual	23	30	23	41	18	31
Total	100	100	100	99	100	99
n	(35)	(10)	(90)	(29)	(55)	(16)
chi-square	.21		3.56		1.27	
p	.64		.06		.26	

*S=Scientific, T=Traditional

Table 5: HEALTH BELIEFS AND THE UTILIZATION OF REMEDIES BY AGE

	Age Group					
	Young		Middle-Aged		Aged	
	Health Beliefs		Health Beliefs		Health Beliefs	
	S (%)	T (%)	S (%)	T (%)	S (%)	T (%)
Remedies						
Single	89	70	73	59	86	75
Dual	11	30	27	41	14	25
Total	100	100	100	100	100	100
n	(35)	(10)	(90)	(29)	(55)	(16)
chi-square	2.04		2.25		.96	
p	.15		.13		.33	

Table 6: HEALTH BELIEFS AND THE UTILIZATION OF HEALERS AND REMEDIES BY AGE

	Age Group					
	Young		Middle-aged		Aged	
	Health Beliefs		Health Beliefs		Health Beliefs	
	S (%)	T (%)	S (%)	T (%)	S (%)	T (%)
Utilization						
Single	74	60	62	41	71	56
Dual	26	40	38	59	29	44
Total	100	100	100	100	100	100
n	(35)	(10)	(90)	(29)	(55)	(16)
chi-square	.77		3.89		1.22	
p	.38		.05		.27	

found that age does make a difference in the utilization of healers. Older people which includes the middle-aged and aged categories were more likely than younger people to show consistency in the relation of belief to use of healer. On the other hand, there is a greater consistency of belief and choice of remedy for younger than older people. It appears that older and younger clients are led in slightly different directions by their beliefs when they have already accepted an element of scientific medicine in their lives. In any case, age seems to influence the degree of consistency of belief and utilization, a conclusion further reinforced by combining healers and remedies in a single measure and controlling for the effect of age on the relationship of belief and total utilization.

Gender and Utilization

While it has been found that women have higher rates of use of health services than men, the literature concerning the influence of culture on utilization does not show a relation between gender and dual utilization. The fact that women are more often than men involved in healing activities in traditional cultures, suggests that gender should influence the relationship between beliefs and utilization. Tables 7 through 9 report the results. The results for the utilization of healers and the combined utilization of healers and remedies suggest, as expected,

Table 7: HEALTH BELIEFS AND THE UTILIZATION OF HEALERS BY GENDER

	Gender			
	Men		Women	
	Health Beliefs		Health Beliefs	
	S (%)	T (%)	S (%)	T (%)
Healers				
Single	78	69	79	64
Dual	22	31	21	36
Total	100	100	100	100
n	(40)	(16)	(140)	(39)
chi-square	.47		3.44	
p	.49		.06	

Table 8: HEALTH BELIEFS AND THE UTILIZATION OF REMEDIES BY GENDER

	Gender			
	Men		Women	
	Health Beliefs		Health Beliefs	
	S (%)	T (%)	S (%)	T (%)
Remedies				
Single	95	69	76	64
Dual	5	31	24	36
Total	100	100	100	100
n	(40)	(16)	(140)	(39)
chi-square	7.20		2.10	
p	.01		.15	

Table 9: HEALTH BELIEFS AND THE UTILIZATION OF HEALERS AND REMEDIES BY GENDER

	Gender			
	Men		Women	
	Health Beliefs		Health Beliefs	
	S (%)	T (%)	S (%)	T (%)
Utilization				
Single	75	62	65	46
Dual	25	38	35	54
Total	100	100	100	100
n	(40)	(16)	(140)	(39)
chi-square	.88		4.55	
p	.35		.03	

that women are more consistent than men in their beliefs and behavior. For the utilization of remedies the results suggest that there is only a negligible difference in consistency between men and women. Healers in traditional cultures have more specialized knowledge about healing and are consulted when the individual is in a crisis. The use of remedies without consultation occurs under non-critical as well as critical conditions. Therefore, since women are more often involved in healing activities, they would more readily go to traditional healers.

Education and Utilization

Another factor which is recognized as having an influence on the use of health services is level of education. In the general utilization literature, education is considered an important influence on the use of health services. In the cultural differences literature, education is considered important as having an independent influence or as possibly modifying cultural influences. In addition, level of education indicates degree of sophistication and as such it may be argued that it is the less sophisticated people who are most likely to use alternatives to scientific medicine. A cultural explanation of health-related behavior suggests the contrary: that level of education will not make a difference in the consistency between beliefs and behavior. Tables 10 through 12 report the results when we controlled for education. It was found that low (less than 8th grade) and middle (some HS and HS graduates) education levels are more likely than more highly (some college and higher) educated clients to be consistent in the relationship of belief and the utilization of healers. The fact that the number of people in the highly educated category is very small may invalidate the comparison. Assuming it is valid, it may be the case that more educated people may be less willing to say that they have sought the advice of a traditional healer. For

Table 10: HEALTH BELIEFS AND UTILIZATION OF HEALERS BY EDUCATION

	Education					
	Low		Middle		High	
	Health Beliefs		Health Beliefs		Health Beliefs	
	S (%)	T (%)	S (%)	T (%)	S (%)	T (%)
Healers						
Single	80	62	77	50	67	83
Dual	20	38	23	50	33	17
Total	100	100	100	100	100	100
n	(113)	(40)	(53)	(8)	(12)	(6)
chi-square	4.65		2.69		*	
p	.03		.10			

*The cells were too small to compute statistics.

Table 11: HEALTH BELIEFS AND THE UTILIZATION OF REMEDIES BY EDUCATION

	Education					
	Low		Middle		High	
	Health Beliefs		Health Beliefs		Health Beliefs	
	S (%)	T (%)	S (%)	T (%)	S (%)	T (%)
Remedies						
Single	82	68	76	62	75	50
Dual	18	32	24	38	25	50
Total	100	100	100	100	100	100
n	(113)	(40)	(53)	(8)	(12)	(16)
chi-square	3.82		*		*	
p	.05					

*The cells were too small to compute statistics.

Table 12: HEALTH BELIEFS AND THE UTILIZATION OF HEALERS AND REMEDIES BY EDUCATION

	Education					
	Low		Middle		High	
	Health Beliefs		Health Beliefs		Health Beliefs	
	S (%)	T (%)	S (%)	T (%)	S (%)	T (%)
Utilization						
Single	69	50	64	50	58	33
Dual	31	50	36	50	42	67
Total	100	100	100	100	100	100
n	(113)	(40)	(53)	(8)	(12)	(6)
chi-square	4.64		*		*	
p	.03					

*The cells were too small to compute statistics.

the utilization of remedies and the combined utilization of healers and remedies the results are statistically significant for the lowest level of education. For the middle and high levels, the cells were too small to compute the chi-square test. Nevertheless, the percentage differences indicate a strong relationship between beliefs and utilization at both of these educational levels. It was felt that the categories should not be collapsed in this case since there is a strong enough distinction to be made between high school and college educated persons.

Thus, the pattern of results is consistent with the hypothesis and reinforces the cultural frame of reference from which it was derived.

Generation and Utilization

The findings and assumptions in the literature concerning the influence of generation on adherence to traditional healing systems is contradictory. Zborowski suggests that later generations tend to be more congruent than earlier generations with the dominant culture in-their behavior but not in their attitudes toward illness. Press suggests that dual use varies according to level of acculturation, which we can reasonably assume is closely associated with generational status.[2] In order to see if generation modifies the relationship of belief and behavior, generation was introduced as a control variable. Generation was measured by responses to items on the questionnaire[3] that concerned respondent's birthplace and parents' birthplace. If both the parents and the respondent or one parent and the respondent were born in the United States, the subject was considered second generation or later. Any other combination of answers were considered first generation. Fifty-nine percent of the sample was categorized as first generation and forty-one percent second generation or later. It was expected that the first

generation would be more consistent in the relationship between beliefs and behavior since this would represent a stronger cultural grounding. The results are in Tables 13 through 15.

The findings for the combined utilization of healers and remedies are consistent with our hypothesis that the first generation will be more culturally-bound. The findings for the utilization of healers analyzed separately from remedies appear to suggest something different. The results were not as expected for the utilization of healers. The second generation rather than the first, is more consistent in belief and

Table 13: HEALTH BELIEFS AND THE UTILIZATION OF HEALERS BY GENERATION

	Generation			
	First		Second	
	Health Beliefs		Health Beliefs	
	S (%)	T (%)	S (%)	T (%)
Healers				
Single	72	66	84	64
Dual	28	34	16	36
Total	100	100	100	100
n	(104)	(37)	(93)	(22)
chi-square	.54		4.55	
p	.46		.03	

Table 14: HEALTH BELIEFS AND THE UTILIZATION OF REMEDIES BY GENERATION

	Generation			
	First		Second	
	Health Beliefs		Health Beliefs	
	S (%)	T (%)	S (%)	T (%)
Remedies				
Single	61	49	73	55
Dual	39	51	27	45
Total	100	100	100	100
n	(87)	(35)	(93)	(22)
chi-square	1.56		2.90	
p	.21		.09	

Table 15: HEALTH BELIEFS AND THE UTILIZATION OF HEALERS AND REMEDIES BY GENERATION

	Generation			
	First		Second	
	Health Beliefs		Health Beliefs	
	S (%)	T (%)	S (%)	T (%)
Utilization				
Single	74	60	86	77
Dual	26	40	14	23
Total	100	100	100	100
n	(87)	(35)	(93)	(22)
chi-square	2.17		1.03	
p	.14		.31	

practice. This finding may indicate that Press[4] was correct when he predicted that the pattern of dual use was going to increase in urban areas. Along with this trend, he argues that the social and cultural supports are not only present for this pattern but that the pattern of dual use performs certain crucial social and cultural functions. In addition, second generation members do have a relatively more consistent experience of both the organizational and cultural aspects of their ethnic group than those who recently migrated and had to re-establish themselves in a new settlement. For the utilization of remedies, both first and second generations are similar in their consistency in belief and practice. This finding suggests that use of remedies is a stronger expression of culture than use of healers. Therefore, there may not be a generational difference with regard to overall cultural integration.

Illness and Utilization

According to the model that is widely used to account for differences in the utilization of health services that was discussed in Chapter Two, illness or perceived need is considered a major determining variable. As far as cultural factors are concerned, it is expected that illness or perceived severity of illness will not influence the

consistency of belief and behavior. Thus, we expected to find no differences with regard to the illness variable. The results are reported in Tables 16 through 18. For

Table 16: HEALTH BELIEFS AND THE UTILIZATION OF HEALERS BY PERCEIVED SEVERITY

	Perceived Severity					
	Mild		Moderate		Severe	
	Health Beliefs		Health Beliefs		Health Beliefs	
	S (%)	T (%)	S (%)	T (%)	S (%)	T (%)
Healers						
Single	75	69	78	69	81	45
Dual	25	31	22	31	19	55
Total	100	100	100	100	100	100
n	(49)	(16)	(88)	(29)	(42)	(11)
chi-square	.29		1.07		5.65	
p	.59		.30		.02	

the utilization of healers, the relationship between belief and utilization was weak for people with mild or moderate illness. For people with severe illness the relationship was statistically significant, though this was based on small numbers. Assuming that this relationship holds, it suggests that people who perceive their illness as severe may be more likely than others to consult a

Table 17: HEALTH BELIEFS AND THE UTILIZATION OF REMEDIES BY PERCEIVED SEVERITY

	Perceived Severity					
	Mild		Moderate		Severe	
	Health Beliefs		Health Beliefs		Health Beliefs	
	S (%)	T (%)	S (%)	T (%)	S (%)	T (%)
Remedies						
Single	82	81	76	55	86	73
Dual	18	19	24	45	14	27
Total	100	100	100	100	100	100
n	(49)	(16)	(88)	(29)	(42)	(11)
chi-square	0.00		4.65		1.04	
p	.97		.03		.31	

Table 18: HEALTH BELIEFS AND THE UTILIZATION OF HEALERS AND REMEDIES BY PERCEIVED SEVERITY

	Perceived Severity					
	Mild		Moderate		Severe	
	Health Beliefs		Health Beliefs		Health Beliefs	
	S (%)	T (%)	S (%)	T (%)	S (%)	T (%)
Utilization						
Single	67	69	64	45	74	36
Dual	33	31	36	55	26	64
Total	100	100	100	100	100	100
n	(49)	(16)	(88)	(29)	(42)	(11)
chi-square	.01		3.19		5.45	
p	.92		.07		.02	

traditional healer. For the utilization of remedies, the results were different for severe illness than it was for the use of healers, although there is some consistency between belief and practice. People who perceived their illness as moderate produced a statistically significant outcome. For people with mild illness, there was no relationship. For the combined utilization of healers and remedies we found statistical significance for people who perceived their illness to be severe and a strong relationship for moderate illness. Again, there was no relationship for people with mild illness.

Overall, these findings are not entirely consistent with the hypothesis. However, they suggest that people who perceive their illness as moderate or severe may be most consistent in their beliefs and behavior. This may be the case because it is possible that perceived severity may be linked to the chronic aspect of the person's illness. In that case, clients who perceive their illness as more serious, may feel more dependent and, therefore, more likely to rely on traditional sources of healing than on mainstream sources.

Summary

In general, our findings support the hypotheses of the study. The prevalence of dual utilization suggest

that there are other than medical considerations in decisions concerning the utilization of health services. In particular, it appears health beliefs have an important influence on utilization behavior relatively independent of education and illness. If a person holds to traditional health beliefs he or she is more likely than someone who does not, to use the healing resources of both scientific medicine and traditional healing. Within the context of dual utilization a distinction is necessary between healing agent and remedy. While results conform to the hypotheses when these two indices are combined, there are differences when they are analyzed separately which is suggestive for further research. In addition to the possibility that chronicity may influence the relationship between belief and behavior, perceived severity of illness may be another influencing variable. As was expected age, gender, and generation affect the relationship between beliefs and behavior. The results for generation, however, are particularly suggestive for further research within a cultural context.

The foregoing analysis supports the argument that cultural factors are a significant influence in the health-related behavior of Third World groups in urban areas. There are several policy implications for medical practice as well as implications for further research that flow from

this study that are presented in the next and concluding chapter.

NOTES

[1]Press, "Urban Folk Medicine," pp. 79-84.

[2]As was indicated earlier, Press equates level of acculturation with socioeconomic status which may not be justifiable.

[3]See items #8, #9 and #10 in the Appendix.

[4]Press, "Dual Use" and "Urban Folk Healers."

Chapter Five: CONCLUSION

The following is a summary of the argument presented here that proposes the significance of a cultural framework to issues concerning health and healing: (1) people act on the basis of their beliefs according to a situation; (2) beliefs may be grounded in either culture or experience; (3) circumstances may determine whether a person acts according to belief that is based on cultural imperatives or belief that is based on experience; (4) beliefs that concern the body and well-being are culturally grounded; (5) therefore, beliefs about health and healing tend to be grounded in culture regardless of experience; (6) since people act according to those beliefs that have more force than experience, health-related behavior should be consistent with beliefs related to health and healing; (7) given the strength of cultural imperatives in shaping individual dispositions, the consistency of belief and practice should be independent of non-culturally based individual characteristics and experiences.

Given this argument, when culturally prescribed healing systems are socially and physically available, people are likely to use them. In the case of Third World groups living in urban areas, traditional healing systems are

often well established. These systems are inconsistent with the culture of scientific medicine upon which the mainstream health care system is based. Under these conditions, dual utilization may be considered expected and rational. Chronic illness creates a special dependence of clients on health professionals that seems likely to exacerbate this normal intercultural tension.

Medical Practice

There are several policy implications for medical practice on the interpersonal level between health professionals and clients and on the structural level of the health care system that follow from the research reported in this dissertation. In general, health professionals should adopt a treatment style that is culturally sensitive. Practitioners need to be made aware that there are cultural differences related to health and healing among cultural groupings that must be respected if the client is to relate rationally to a treatment plan. A part of this awareness involves the recognition that scientific medicine itself has a cultural basis. Client innovations beyond the imperatives of scientific medicine or the expectations of health professionals may not be due to ignorance or lack of sophistication but to the need of the client to satisfy norms of well-being that are consistent with his or her

cultural background. Once professionals in the health care system gain this awareness, they will be in a better position to care for not only Third World groups, but people in general since this general attitude would be helpful for other cultural groups as well as for women and older people who also experience discrimination.

If a practitioner should encounter a client whom he or she has reason to believe adheres to culturally grounded health beliefs or is engaging in traditional healing practices, the practitioner needs to be able to handle this situation effectively. That is, the practitioner needs to display a sensitivity to possible alternatives without being judgmental and without discouraging the client to the point where his or her health may suffer as a result. Strategies can be created whereby clients can utilize more than one system of healing as long as achieving positive results, i.e., improved health, is made the overall goal. Many practitioners may take the position that to entertain alternative forms of healing is irrational. However, as was mentioned in Chapter Two, psychology and psychiatry have recognized these issues on both the levels of research and practice as having great import. To give an obvious example of achieving greater sensitivity in certain areas, some mental health clinics that serve a largely Latino clientele have introduced the presence of

spiritualists into their practice.[1] This strategy is one way of overcoming the cultural clash between scientific medicine and traditional healing systems.

The following suggestions are made toward achieving the goal of greater cultural sensitivity. First, genuine communication presupposes respect for the client as a person and rapport between practitioner and client based on such respect. In some cases, members of the client's family should not only be referred to, but should be included in the medical encounter and in treatment plans out of respect for cultural traditions. Second, an open non-judgmental attitude towards the client's beliefs, expectations, and values is part of the spirit of compromise that is essential for the client's full participation in treatment plans. Third, health professionals must do the interpersonal work necessary to reduce social, economic, and cultural distance between themselves and their clients. Fourth, in cases where a community has well-established ethnic or cultural groups, the health care institutions and professionals in these communities need to become familiar with the cultures of those groups ahead of time, particularly with their beliefs and practices concerning health and healing. Fifth, as part of the medical encounter, the health professional should evaluate to what extent the client's medical condition needs to be interpreted in the

light of culturally-determined concepts of disease and illness. If there is any reason to believe that the client's cultural background does figure importantly in his or her health beliefs and behavior, the health professional should elicit the client's conception of the problem. One of the inquiries that ought to be made is: "What do you think caused your problem?" The client should be encouraged to become an active participant in the encounter. Sixth, once the client's ideas are known, the health professional has to deal with discrepancies between the client's conceptual scheme and the biomedical perspective. In order to deal effectively with discrepancies, the treatment plan should be formulated in such a way as to include compromises to which all parties clearly agree. In addition, when treating clients who have indicated, verbally or otherwise, a preference for alternative modes of treatment, these should be incorporated into treatment plans. Seventh, when the situation calls for it, there should be consultation and cooperation between health care professionals and traditional healers, an approach which has been successful in the field of mental health.[2]

Communication can be improved by several other practical strategies that deal with some of the more subtle aspects of the medical encounter. Since verbal communication is often limited in the medical encounter, clients

look for other cues to gain information about themselves and their problems. The professional's nonverbal behavior is extremely important in conveying information and may, if not handled well, be a source of ambiguity. In order to create an atmosphere of warmth, caring, and understanding, and a sense of mutual respect, the health professional should establish good eye contact and use appropriate facial expressions, tone of voice, posture, and gestures. In addition, he or she may, if appropriate, shake hands or use a polite touch on the hand (not on the head) to reduce social distance and convey sympathy and understanding.[3]

Furthermore, complications in communication arise when the client is not only from another culture, but speaks very little English or none at all. Initially, the health professional should not make any assumptions about language competence, but should ask the client what language he or she would prefer to use. If the person prefers his or her native language, a trained interpreter with a medical background should be available for interpreting--not a relative or a child or a convenient stranger. This is an important consideration because otherwise there are dangers of mistaken interpretation, violations of privacy and/or confidentiality, violations of cultural traditions, and the accidental introduction of extraneous and possibly

detrimental information into the encounter.[4] An even greater effort must be made to sustain rapport with non-English speaking clients using the guidelines listed above since there is a tendency to direct conversation to the interpreter when present and to neglect the client.

Several suggestions on the structural level can be made as well toward achieving the same goals. One area in which practices can be modified is in medical education and training. First, a serious effort on the part of the health care system to incorporate people from varied ethnic and economic groups, as well as more women, from all groups, into the ranks of health professionals especially physicians, would not only help in the day to day issues that arise in medical settings, but would be a beginning in demonstrating an openness and sensitivity on the part of the health care system to the social and cultural issues raised here. Second, the considerations related to cultural differences can be incorporated into the formal education and training that health professionals receive. Curricula could incorporate these concerns both in courses designed for the specific purpose and as a part of all courses. Third, clinical settings can be modified to accommodate cultural differences. For example, having a presence of traditional healers based on a program of community outreach or making available alternative languages

to English in the use of signs, instructions, prescriptions for medications, etc.

Further Research

There are several implications for further research that follow from the study presented here. A similar study needs to be done on a community-based population. This shift in population focus would eliminate the bias of studying a population that already uses the health care system. This would give a fuller understanding of the social organizational bases of health beliefs and practices and their prevalence. It would also be interesting and enlightening to study alternative healing systems focusing on those of Third World groups in urban settings. To go further into cultural background of utilization, it may be interesting to study socialization patterns to gain a clearer understanding of how these processes operate and their impact on behavior. Further, more information is needed about the phenomenon of dual utilization: e.g., to what extent does it exist in the general population, what impact does it have on health status, etc. In addition, related to dual utilization is the distinction between healers and remedies. This distinction needs to be explored further in relation to the decision-making process concerning patterns of utilization. The impact and effectiveness

of traditional healers and practices needs fuller study than has been done. Finally, the impact that sociocultural factors, i.e., age, gender, and generation, have on the cultural influences on utilization patterns needs further exploration.

NOTES

[1]This has been achieved at Lincoln Hospital in the Bronx, New York.

[2]c.f. Harwood; Henderson; and Saunders.

[3]c.f. DiMatteo and DiNicola.

[4]c.f. Fearon. The author observed many of these difficulties in the course of field work for this study.

#2. Would you say that the symptoms you had at that time were mild, moderate, or severe?

___ mild
___ moderate
___ severe

#3A. Since that time did anyone give you a name for the problem you have?

___ yes (ask 3B)
___ no

#3B. What is the name? (IF DON'T KNOW OR RESPONDENT HAS DIFFICULTY: READ LIST). Is it:

___ osteoarthritis
___ rheumatoid arthritis
___ lupus (SLE-systemic lupus erythematosus)
___ arthritis
___ rheumatism
___ psoriatic arthritis
___ gout
___ ankylosing spondylitis
___ mixed connective tissue disease (MCTD)
___ Reiter's syndrome
___ bursitis
___ scleroderma
___ other (SPECIFY) _____
___ don't know (CANNOT ASCERTAIN)

#4. How would you describe your symptoms now? Are they a lot better, somewhat better, the same, or worse.

___ a lot better
___ somewhat better
___ the same
___ worse

#5. People belong to different ethnic groups. Some people say they're black, some people say they're Puerto Rican, some people say they're Jamaican. What would you say your ethnic group is?

___ black	___ Cuban
___ white	___ Trinidadian
___ Puerto Rican	___ Barbasian
___ Haitian	___ Panamanian
___ Dominican	___ Other (SPECIFY) _____

#8. Where were you born? (Include city, state, country.)

#9. Where was your mother born? (Include city, state, country.)

#10. Where was your father born? (Include city, state, country.)

#48. People have many explanations about what causes illness. For each of the following explanations please tell me whether you agree, whether you think it may have some truth to it, if it is doubtful, or whether you disagree.

	Agree	Some truth	Doubt-ful	Dis-agree
A. Some people think illness is brought on as punishment.				
B. Some people think illness is caused by germs.				
C. Some people think illness is caused by evil forces.				
D Some people think illness is caused by being exposed to too much cold or too much hot.				
E. Some people think a person stays healthy through good fortune or good luck.				
F. Some people think illness may be caused by someone casting a spell or putting a hex or roots on a person.				

	Agree	Some truth	Doubtful	Disagree
G. Some people think the evil eye (mal de ojo) brings on illness.				
H. Some people think psychological or nervous problems bring on illness.				

#53. I am going to read you a list of the different kinds of people that are used for health problems.

A. Which ones have you used in the past?

___ nurse
___ pharmacist
___ spiritualist
___ herbalist
___ medical doctor
___ relative
___ fortune teller
___ root doctor
___ chiropractor
___ friend
___ santero(a)
___ advisor
___ nutritionist
___ self
___ curandero(a)
___ physical therapist
___ old lady
___ faith healer
___ acupuncturist
___ person in botanica

#54. I am going to read you a list of different kinds of treatments that are used for health problems.

A. Which ones have you used in the past?

___ prescription drugs
___ herbs
___ liniments
___ physical therapy
___ massage
___ vitamins
___ copper bracelet
___ exercise
___ live with it/ nothing
___ seance
___ tonic
___ apply heat
___ apply cold
___ wait for it to go away
___ prayer
___ warm bath
___ bath with solution
___ tea

#55. There may be differences between medical doctors and other healers. Would you say they are different or the same in the following ways:

	Different	Same
How trustworthy they are?		
How they treat illness?		
How much you understand them?		
How friendly and sympathetic they are?		
What they know?		

__never went to another healer

#60. What is the last grade you finished in school?

___ less than eighth grade
___ some high school
___ high school graduate
___ some college
___ college graduate
___ graduate/professional school

#61. What age group are you in?

___ younger than 20 years
___ 21-29 years
___ 30-39 years
___ 40-49 years
___ 50-59 years
___ 60-69 years
___ 70 years or older

#70. Now I will read the same categories. Please stop me when I have reached the income groups that your family fell into last year. Please include earnings and all other sources of income like tips, gifts, and winnings for all the members of your household.

___ under $2,000
___ $2,000-3,999
___ $4,000-5,999
___ $6,000-7,999
___ $8,000-9,999
___ $10,000-11,999
___ $12,000-13,999
___ $14,000-15,999
___ $16,000-17,999
___ $18,000 and over

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