THE PATIENT'S EXPECTATIONS : A Cultural Perspective

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要　旨

人のその人なりの性格や傾向は、教育の程度や遺伝的な気質、環境のみによって決定されるものではなく、文化的背景によって決まる。この論文はこの文化的背景によって決定されるであろう患者の期待や予測、健康管理の質について論じる。

Abstract

Human beings are products not only of nature and nurture in varying degrees, of genetic disposition and environmental and care factors impinging on the expression of characteristics and tendencies, but also of cultural programming. This paper looks at some of the cultural legacies determining patients' expectations of the type and quality of health care they will receive.

A 1980 cross-racial study by molecular biologist B.D. Latter, found that there is more variation within racial lines than across them. His study demonstrated less than 15% of variation is of the latter type, and this of superficial characteristics such as hair type, skin and eye colouring, eye, nose and cheek shape, and the deposit of fat. If then, human beings are so very similar, it should follow that the reaction to illness, to disease, and to their treatment should differ little worldwide. In fact, because of cultural expectations, this is not so. In this paper, we examine patients from five national groups as to their expectations of the medical establishment, and regarding treatment.

Let us begin with health care systems. There are several ways of looking at a health care system. One is as a government function, with aspects of distribution, regulation of fees, services, and entitlements, accountability, funding, costing and the like. The other is to think about medicine as a cultural system in exactly the same way we speak of religion or language or kinship as cultural systems. We can look at what people believe it means to be sick or to be well, what people think causes sickness, where does responsibility lie for sickness and health, within the individual, with some external agent, with fate, with God? What is the power structure in the system, what roles are played, and what are the inter-relational aspects to the delivery of health care? And of course, in any health care system, especially viewed from an intercultural perspective, the governmental, regulatory structure and the cultural patterning aspects have all to be considered.

So far as the institutionalising of health services by government is concerned, it is necessary to note a major medical shift that is affecting every health care system. In the early part of the twentieth century a doctor, anywhere, would be called upon in the main to deal with contagious diseases such as whooping cough, influenza, TB, gastroenteritis, or with emergencies such as falling under a train, being burnt by molten metal or mutilated by machinery, or being kicked in the ribs by a horse. Also he, almost always a he, would deliver babies, dress wounds, splint up broken bones, and he would make house calls. He did not have chronically ill patients living for decades, requiring regular kidney dialysis, femoral by-passes and the like. The majority of health care systems, products of the middle part of this century, were put into place to deal with the maintenance of basic health, check ups, preventative measures, and to cope with emergencies. No system that we have today started off with any idea that it would have to deal with chronic care on a massive scale, for which there was no funding, nor that developments in medical technology would be such that incredibly sophisticated machinery worth millions of dollars would come to be expected as part of routine health delivery. The local hospital that a few years back could be regarded as well-equipped if it had an X-ray machine and an operating theatre, now is expected by the public to have not just an X-ray machine, but a Bone Density Scanner, a Magnetic Resonance Imager, Ultra-sound and Computer Assisted Tomography equipment as a matter of course. Ironically, many small hospitals in Japan have all of this, but because of budgetary constraints, lack the specialised technicians to operate it.

Thus to a greater or lesser extent, depending on the culture, there is an expectation of high-tech, quick-fix solutions, solutions which cost a lot of money, but nowhere is there the economic base to sustain the expectation. Because medicine has done such a good job of improving life expectancies and cutting infant mortality rates, we have great population pressures. Not unrelated to this, questions which hitherto wese little debated outside university philosophy departments, have become major political issues, the right to life, the right to die, the morality of genetic engineering and related

topics. Malpractice suits, unheard of thirty-five years ago, now constitute a factor, a costly one, in Western medicine. But not in Eastern medicine and certainly not in Japanese medicine. There are more attorneys in Los Angeles alone pursuing careers in malpractice, than there are lawyers in the whole of Japan covering the gamut of legal proceedings. In the rare instance that a medically related legal action might be taken in Japan it would almost always be a class action, against a company, a hospital or a health authority such as the blood bank. Japanese culture is group and consensus oriented, and personal initiative is discouraged from an early age. The idea that an individual doctor could be held culpably responsible for his action, or that an individual patient might have a personal right of redress for an ill done is almost unthinkable.

Moving now to a little historical background. Modern medicine has had four strong influences, British, American, French and German. The British influence is felt throughout the former empire, the modern commonwealth countries. American know-how which itself grew out of British and German practices, has now become very strong, unique in its approach and widely adopted, including back to Britain and in Germany. French influence is strong not only in France and the French colonies and former colonies, but also in Italy and the Iberian Peninsular, and from Spain and Portugal to South and Central America, and Mexico. German practices have been picked up in Eastern Europe and in Japan. During the Meiji Restoration of 1868, experts were brought into Japan from all over to modernise the country which had isolated itself for almost two hundred years. And in the setting up of education and health care practices, the experts were German. To this day, Japanese high school students wear uniforms reminiscent of the late 19th Century German ones. University entrance exams and curricula reflect German models. Until the 1970s a Japanese doctor's second language would most likely have been German, not English. The German terms roentgen and karta are standard in Japan for X-ray and patient chart respectively.

A cultural trait of American medicine is that it is very aggressive. Americans fight disease, they battle epidemics, they hurl all the pharmaceutical weapons at their disposal at invading microbes, they do all they can to eliminate disease and pestilence. Whatever can be transplanted, whatever can be modified, operated on, altered, or drugged, is. American medicine tends to treat maladies as isolated instances of aberration, and, as much of that society concerns itself with individualism, so medicine looks to reduce each problem to one location, one cause, one solution. Medical technology of increasing complexity and sophistication pours from American laboratories and research institutes. In the United States most packages of food, drink, proprietary medicine, most items of personal hygiene and grooming such as toothpaste, soap, cosmetics and perfume, are annotated as to what they contain and the conceivable harm that may arise from using them. Warnings abound and the average citizen expects the government to protect him from himself. Medication is strictly controlled by government agencies and many products cannot be obtained without a prescription.

Many an American patient considers himself a consumer, with all the rights to redress and to service that being an American consumer entails. He expects instant medical attention whenever he is ill. He obliges doctors to fix whatever ails him. He believes full health and care to be his right, practically guaranteed by the Constitution, and in consequence takes little responsibility for his own state. Should the system fail to live up to this expectation, this patient will think nothing of suing his medical practitioners for negligence or incompetence. So great is the competition for patient clients between doctors in some American

states that they advertise their services in the media. In an effort to make time spent with the doctor as attractive, some say as effective as possible, clinics are designed by decorators, and the doctor usually addresses the patient, whatever his or her age, by the given name. This is what the consumer patient expects.

Compared to the American attitude, the British approach is a much more conservative one, although still reductionist. A British doctor is far more likely than an American doctor to take a "wait and see" attitude to whatever symptoms patients present. Dosages prescribed are generally weaker than would be routine in the United States, and whereas the American attitude could be summed up as "pro-active", the British one is "less is more". Patients on the National Health Service must register with a particular doctor in their area, when he or she has a vacancy to accept a new case load. Unless a patient's condition is critical, it is not possible to see a doctor without an appointment, and even with one waiting is not unusual. Though attitudes in Britain are changing, due in large part to increased media coverage of health related issues, the underlying patient attitude is that the doctor knows best and he or she should not be questioned. Expressions such as "I'm under doctor's orders to ....", and "the doctor said I have to...." are standard. British patients do as they are instructed and if a treatment is unsuccessful, they are more likely to take a stoic attitude than to complain. Younger patients may accept the doctor addressing them by given name, but older patients might well quit the clinic if their first name were used. As in the United States, most effective drugs are available by prescription only and the patient expects that his visit to the doctor will be followed by a visit to the pharmacy to buy medicine.

The French, and by spill on influence the Iberians, Hispanics and Latins, grow up with medical traditions that treat the whole person. A patient in any of the countries under the French medical aegis, expects that when he goes with a health problem to a professional, that practitioner will spend a great deal of time with him. He will be asked not only about the specific symptoms which caused him to seek advice, but about his life-style, his job, his family and business conditions, in short, every aspect of his life that could conceivable impact on his wellness and well-being, or lack thereof. In French clinics devoted to chronic care concerns, it is not unusual for a patient, and the immediate family care-givers, to be assigned to a team consisting for example of physician, physiotherapist, nurse, psychologist and nutritionist. The patient expects to play an active part in his own recovery, or in the management of his condition. He expects to receive a deal of personal attention, treatment of the most advanced technical kind allied to alternative palliatives, and he expects the bulk of the payment for such services to be borne by the state.

The expectation of whole person care, modern and traditional medicine, and much time spent with a patient, applies equally to other states under original French medical influence. However, with the possible exception of Costa Rica the economy of which is in very good shape, nowhere else besides France has the financial wherewithall to deliver health care to such high standards. Patients in Latin America know that the doctors and nurses will spend time with them and do the best they can, but that care and medicines are not cheap, and not state funded. In Mexico, and in much of Latin America and the Caribbean, doctors expect to spend at least a third of their time working basically as volunteers in municipal health facilities, assisting as best they can with limited means, whoever comes for consultation. Generally, unless the condition is particularly serious, patients will not seek medical advice. Though doctors receive little money, it is the rare day when they do not go

home with a chicken, a fish, a bag of vegetables or fruit, or some comestible offered in payment by a grateful patient. The use of title and surname is routine in these countries. As for medication, though a drug may be administered or a prescription written if one sees a doctor, the patient rather expects to go to any drugstore and buy whatever the pharmacist, or drug store assistant suggests based on what he, the patient, thinks he needs.

German health care today is moving a little in the direction of French norms, albeit slowly. In the past though, the state run medical system paid doctors a rather small amount of money for each patient seen or prescription dispensed. Because failure to keep appointments could reduce the number of patients potentially seen in a day, the appointment system was not in the past encouraged. In Japan where Germany's model was adopted, doctors are similarly reimbursed for the number of cases dealt with and prescriptions written. As in Germany, appointments are rare, and over-prescription rife. German and Japanese patients expect to be prescribed up to five different medicines at a time, and that the doses will not last more than a few days, necessitating a return visit to the clinic, and additional government rebates for the physician. In both countries, the patient expects the doctor to treat him very formally, using the family name and maintaining a physical distance. Patients in both countries know that they should not ask questions and even if they do they are unlikely to get a detailed answer. Patients do not expect to be told what medication they have been given or what its effect or side-effect may be. As, according to newspaper reports, in both countries much of the medication is consigned to the toilet before entering the alimentary tract, little physical harm comes from the over-prescribing practice.

Both Japan and Germany are very open to "alternative therapies" which are in fact so common as to be main-stream. Doctors regularly counsel treatment which includes herbal preparations, manipulations, and the like. In Germany all patients are commended to spend time annually at a spa, to get out into nature, and to nourish their souls with beautiful views and good music. In Japan the onsen, nature walks, and the restorative power of beauty are similarly encouraged.

Many countries in the world today are facing problems associated with burgeoning greying populations in need of care, both medical and nursing. Japan is having to deal with this care crisis ahead of many other jurisdictions, and in so doing is in many ways, setting the standard for aged care. What do these aging quasi-patients expect from the government-sponsored system? They have worked all their lives, many have seen great hardship in the post-war years. Certainly, now that the extended family is no longer the norm, the elderly do not expect their families to offer much support. To a certain extent, simply because of the paternalistic heritage of this country and because people have unstintingly followed government work exhortations for so long, the elderly don't expect that now in old age they should have to fend for themselves. And from the intense and prolonged debates that have accompanied the setting up the Home Nursing System, it is clear that a feeling of responsibility for the care of the elderly transcends party political lines.

This paper gives but a short overview of a limited number of patient expectations. However, we hope that from this, the reader may glean some idea of the mediating role culture plays in the management of illness.

Endnote

1. "In 1980, molecular biologist B. D. Latter examined how proteins vary both within and across race. He discovered that 84 percent of the variation came from within race. In other words, we are genetically much more similar to many

individuals in other races than in our own."

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