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Cultural Diversity, Alternative Medicine, and Folk Medicine

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Throughout its history the ethnic and cultural diversity of the U.S. population has grown constantly. During much of that time established American groups assumed that newcomers would be assimilated into existing cultural patterns; this was the "mel ting pot." Now, late in the 20th Century, this assimilation model has been recognized as neither a good description of what has happened nor a plausible prediction of what can happen as our population continues to diversify rapidly. The li nguistic, religious and other cultural patterns of American society are now more varied than ever, and medicine, like other institutions, works to develop appropriate methods for a pluralistic society. The physician entering practice in the year 2000 wil l face both a patient population and a set of professional values that require skills for negotiating cultural difference.

In an essay entitled "Culture and Clinical Care" in JAMA (March 2, 1994), pediatrician Lee Pachter discussed the clinical importance of cultural differences in beliefs about health and disease, using the folk medical beliefs of Latinos to illustrate the point. More recently the 3rd edition of Mosby's Guide to Physical Examination devotes an entire chapter to cultural awareness, emphasizing cultural values and beliefs and their impact on health behavior and, therefore, on care. The Mosby's chapter provides a chart of cultural characteristics, including a column of health and diet practices, for Americans from ten different ethnic groups including Chinese Americans, African-Americans, Mexican Americans and Native Americans. The health practices listed range from the use of herbs and dietary manipulations to acupuncture or acupressure to spiritual practices invoking supernatural intervention.

The importance of such information, as Pachter pointed out, is that people with medically unconventional beliefs may still present in medical clinics for care. In fact, not only is it the case that in "culturally pluralistic settings, people go to ` doctors' for `medical' illness and to `folk healers' for folk illnesses," but also patients sometimes use medical doctors and folk practitioners simultaneously.

Because these cultural differences have medically significant impacts on patient behavior, there have been efforts to identify those patients within various cultural groups most likely to have strong convictions about

"ethnocultural health beliefs an d behaviors." Pachter characterizes those patients by six characteristics; those who

1. are recent immigrants to the mainland United States,
2. who live in ethnic enclaves,
3. who prefer to use their native tongue,
4. who were educated in their country of origin,
5. who migrate back and forth to the country of origin, and
6. who are in constant contact with older individuals who maintain a high degree of ethnic identity.

(p. 130)

Pachter says that these people may be considered less acculturated.

Such publications provide a good start in raising the awareness of health professionals about the cultural dimensions of care. But even though recent writing on this subject has been done in a sensitive and sophisticated fashion, it consistently omi ts one of the largest--probably the largest--group of American patients possessing cultural health beliefs and practices that are medically unconventional. These are American-born, English-speaking, middle class people with college educations. Ev ery good study of medically unconventional health beliefs and practices in the past twenty-five years has shown that this group possess and acts on a great variety of health beliefs and practices--including many borrowed from the cultural groups cited in Mosby, Pachter and other publications on cultural diversity.

The best quantitative study to date was published in 1993 in The New England Journal of Medicine by David Eisenberg, M.D., and colleagues at Harvard. Their large national survey found that 34% of those surveyed used alternative medicine, and those with more education and higher income were most likely to use it. The Harvard study simply confirmed earlier work, including a 1986 Harris poll done for Health and Human Services. There may be some regional differences, but studies in central Penn sylvania have shown the same phenomenon.

Now it is true that middle class American English speakers fit rather well with Pachter's criteria. They do tend to live in "ethnic enclaves," they "prefer their native tongue," they were "educated in their country of origin," and they do have conta ct with "older individuals who maintain a high degree of ethnic identity." But this is clearly not what Pachter had in mind. These patients are not recent immigrants, and they do not have to "migrate frequently to their country of origin." They are mos t definitely not "less acculturated." And yet they share with "recently arrived groups" the simultaneous use of conventional medicine and a whole host of other treatments ranging from self care to healers operating outside medicine. Interestingly, there is even some recent evidence that newly immigrated groups share the tendency for the more acculturated members to be the most likely to use their culture's "folk medicines." For example, a study published in 1990 found (to the authors' surprise!) that t hose most likely to utilize traditional Korean health practitioners such as acupuncturists and herbalists were "the most educated and assimilated Korean immigrants."

How can we account for this apparent paradox? Perhaps the first step is to account for the very fact that it seems paradoxical. One hundred years ago health care in America was provided by a welter of competing "medical sects." It would not have b een news to anyone that patients in the American "mainstream" frequently utilized a great variety of "alternative practitioners." In 1910 when Abraham Flexner published his famous report which revolutionized medical education, part of his purpose was to bring an end to the popularity of folk and alternative health practices in favor of scientifically grounded medicine.

By establishing consistent standards for the scientific and clinical education of physicians, Flexner expected that homeopathy, chiropractic, osteopathy, Christian Science--in short systems competing with regular or "allopathic" medicine-- would disa ppear. With good education and science, medicine would come to include everything that research showed to be effective. What was not shown to be effective would wither and die. There would not be different kinds of medicine (apart from legitimate medic al specialties). There would just be good, rationally founded medicine.

The regulatory developments that followed did have substantial success in suppressing competition to regular medicine, but although the competing practices were rendered considerably less visible for several decades, they did not disappear. In fact they flourish now. They are represented by the Office of Alternative Medicine at NIH. They are increasingly being covered by insurers. And studies such as those by Eisenberg show that they command a very substantial share of the health care market.

For sixty or seventy years after the Flexner Report, alternative medicine, generally called "folk medicine" or "unorthodox medicine," sometimes "marginal medicine," was studied by several disciplines, and the particular interests and approaches of ea ch have had an impact on current images. Anthropologists have traditionally studied non-Western cultures, including their medical systems. In recent years they have increasingly turned their attention to the United States, but their selection of populati ons for study continues to be influenced by their discipline's history. They have therefore tended to focus on new immigrant groups, Native Americans and others isolated from the cultural mainstream by political, ethnic, linguistic or geographical barrie rs; that is, those who-- as Pachter suggested--are relatively unacculturated to modern, North American culture.

Sociology has generally given less attention to folk medicine. In recent times, however, medical sociologists have shown an increasing awareness that "self-treatment, folk medicine, and home remedies...[are] far and away the major source of health c are in the United States," (Wolinsky 1980, 291). Within sociology the interest in class differences and the importance of the concept of "deviance" has resulted in an image of alternative health practices similar to that produced in anthropology; that is , an image that emphasizes its difference and the distance from scientific medicine.

Finally, the success with which historians of medicine have traced elements of folk medicine back through the millennia has combined with the other trends in health systems research to depict folk or alternative medicine as vestigial. Even Erwin Ack erknecht, a medical historian who cautioned against "medical historians...[being] obsessed with the evolutionary idea," characterized folk medicine as "10% primitive medicine, 50% Galenism and 40% misunderstood modern technology" (1971:7-8).

These academic ideas have created an impression that North American mainstream culture is monolithic and relatively homogeneous, and that education has directly led to a consensus that the bio-medical health care system is the only proper authority o n health. At the same time North American ethnic sub-cultures have come to be viewed as archaic and deviant, at least to the extent that their health beliefs do not reflect and accept modern medical views. But, not only do well educated, native English- speaking Americans--those assumed to be most "acculturated"--have their own array of alternative health practices, they also make use of the practices of other cultures around the world and of immigrant groups! Acupuncture and moxibustion from China, Ayu rveda from India, shamanism from South America, herbs from all over the world, are as influential with middle class Americans today as the classic western European alternative systems such as homeopathy, chiropractic and the health food movement.

What does all this mean? First of all, we should not be too surprised that a cultural circumstance that is ancient and ubiquitous has not changed in just seventy or eighty years. All cultures have diverse health resources ranging from self care and home first aid through a variety of kinds of healer specialists. And those societies that have had substantial cross-cultural contact have always borrowed and assimilated the health beliefs and practices of those with whom they came in contact. America n society is no different in this regard.

Having said that eighty years is not enough time for a single, unified health culture to develop raises the question of how long is long enough. Different observers will have different views of this. I would guess that it will never happen. Diversity in healing, as in other areas of culture, from art to politics to religion to science, can be either good or bad in the particular instance: there is bad politics and there is bad science, and the world is not better for that. However, the wor ld is better for the circumstances that make bad politics and bad science, bad art or bad religion possible--free speech, tolerance, the right to be wrong--all the things that John Stuart Mill cited in his classic argument for the value of free spe ech.

In medicine we might want to imagine that we are different, because we have free inquiry within the institutions of medical science, and outside those institutions there is no basis for real knowledge. That was the turn-of-the-last-century vi ew of progressives like Flexner. But the history of folk and alternative medicine does not bear out that idea. The high fiber diet and reduced animal fat intake were urged by people whom regular medicine called charlatans and quacks, from the mid-ninete enth century until they became conventional health recommendations less than twenty years ago. Acupuncture was used as an illustration of medical irrationality before Nixon's China trip and James Reston's fortuitous appendicitis brought it to the United States. From the impact of the LaLeche League on the advisability of breast-feeding to current studies of botanical medicines such as ginger, *echinacea* and *ginkgo biloba*, folk and alternative medicines have continuously influenced medical r esearch and practice.

And these influences have originated outside conventional medicine. It seems unlikely that western neurology would have created acupuncture. The number of plants in the world and the possible health applications makes it very unlikely that even a p rodigious effort such as the National Cancer Institute's plant screening program would eventually find all useful botanicals for a single disease. Therefore, the experience of millions of individuals in hundreds of different herbal traditions offers a we alth of leads toward plant medicines. And on and on. From religious healing traditions and the research they have inspired on the health effects of meditation (such as Herbert Benson's research at Harvard) to the growing number of studies comparing the spinal manipulation of chiropractors to other interventions for back pain, ideas from outside conventional medicine continue to suggest new investigations and applications. The greater the diversity of theories and observations, the greater the variety o f ideas available for empirical testing.

So, what about the perspective of the new physician in the year 2000? That doctor must recognize cultural diversity--including diverse health beliefs and practices--as characterizing the entire patient population. It is something that new imm igrants have in common with those already here--and something to which they add. It is something that does not fade away in the process of assimilation--rather it becomes more complex. Chinese immigrants have given acupuncture to thousands of Ame ricans just as Indians have been giving Yoga to Americans for generations. At the same time that the United States exports modern bio-medicine around the world, as well as chiropractic and other distinctively American alternatives, it imports and

reconfi gures the health practices of cultures all over the globe. And this growing cultural complexity is neither inherently good nor bad. But it is a fact of life, and it does hold the potential for great benefits.

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> The following essay was first published in Perspectives from the Humanities, a bi-monthly, in-house publication of the Humanities Department at the Penn State College of Medicine. These Perspectives pieces are distributed to all faculty, stu dents and residents in the College. Subsequently I published a modified version in my ethics column in the journal Alternative Therapies in Health and Medicine. This essay, and the two locations where it appeared, provide a small illustration of s ome of the possibilities of "folklore studies applied to health," as I called my applied work in my dissertation (U. Pa. 1974). From current efforts to provide culturally competent health care to the explosion of professional and popular interest in alter native medicine, folklorists have the opportunity to both contribute and benefit (in practical and theoretical terms). It is a great pleasure, after more than 20 years doing this work, to find some folklorists now joining the project, Bonnie O'Connor and Anne Scott being two prime examples. But the amount of work (and nyumber of opportunities) is enoromous--and the competition is increasingly fierce, as these topics explode in prominence. I hope that this new avenue for electronic discussion will help to increase the number of folklkorists who choose to do work in this area.

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