Enrollments of international students have increased dramatically in the last several decades. The delivery of health care to these students has become a topic of study for college health care providers and medical researchers across the country. The purpose of this study was to explore how Asian international students cope with illness while in school at Oregon State University. Interviews were held with international students from Japan, Korea, China and selected health care providers from the Oregon State University health center. Information was sought describing health care issues, and perspectives on medical care. The interplay between the student's perspectives and experiences and those of health care providers was explored as they revealed the role of culture in the cross-cultural medical situation.

In contrast to other findings I maintain that it is the effects of culture, that is, the envisioning of different realities, in similar situations, that affect both patients and practitioners in the cross-cultural medical encounter. American core cultural values, in conjunction with a biomedical paradigm, formulate a base from which university health care providers interpret their clinical reality. Asian international students bring with them to the medical encounter a different paradigm that, for them, provides a definitive view of
illness and health care. It also is grounded in meanings learned from cultural experiences. The anthropological views presented here are powerful and of considerable value in clinical settings because they assist individuals in moving beyond culture-bound realities in order develop a pluralistic perspective that validates the existence of different illness realities in the cross-cultural medical encounter.
Interpretations of Reality:
Cross-Cultural Encounters of Asian Students
with Healthcare at Oregon State University

by

Julie H. Barclay

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CHAPTER FIVE

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CONCLUSION

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 CHAPTER ONE

This thesis research examined how Asian international students from China, Korea and Japan coped with illness while they were in school at Oregon State University. My aim was to use a qualitative research methodology to elicit these students experiences with, and perspectives on, health care in a cross-cultural situation. In light of this then, my goal here is to explore issues of health care as students from Japan, Korea, and China defined them. That is, I seek an understanding of their reality by searching for the meaning these experiences and perspectives hold for them. As Geertz has commented, "What prevents us from grasping what other people are up to is not ignorance...(but) a lack of familiarity with the imaginitive universe within which their acts are signs" (1973:13).

ORGANIZATION OF THE THESIS

It is my intent to accomplish two tasks with this thesis: first to explore the cultural dynamics underlying the perspectives of various groups and individuals; and second to present an analysis of these cultural perspectives as they are revealed through the stories and experiences of Asian international students and health care providers.
Chapter one is an introduction to the research area. Here I briefly highlight the aim of the project, survey the literature specific to the subject, and illustrate some essential differences in core values as a foundation for explaining the nature of the cross-cultural experience. Chapter two provides a review of literature relevant to the thesis. It is composed of two broad domains. First, I present the literature relevant to the study of health and international students, beginning with the early work of physician-researchers and examining the Western scientific perspective as it has influenced their work. Second, I explore alternatives to these ideas through the writings of medical anthropologists. In chapter three I demonstrate how the distinctly Western historical and cultural traditions influence biomedicine as it is practiced in the United States. This chapter supports the arguments made in chapter two regarding the approach to this problem undertaken by previous medical researchers. Additionally it provides a foundation for my interpretation of the perspectives of health care providers in chapter five. In chapter four I explain my choice of research methods and how the information was collected. In chapter five I present and offer my interpretation of the data. Here, I offer my interpretation of the student's realities as they are revealed through their experiences.

With this in mind then it is important to present a definition of culture that frames the ideas presented here and clarifies the orientation of this thesis.

DEFINING CULTURE

It is the nature of human experience that each of us necessarily must interpret the experiences of our lives in a way that is meaningful; that
is, we strive to find ways to make sense of and order the events of our lives. The study of this process is one area that concerns cultural anthropology.

Culture can be likened to a complex web of relationships that are not well defined as separate events or actions taking place in isolation from one another. In this manner culture can be defined as more than shared actions, behaviors, and beliefs. Clifford Geertz has espoused a view of culture that portrays man as an, “animal suspended in webs of significance he himself has spun. I take culture to be those webs, and the analysis of it to be therefore not an experimental science in search of law but an interpretive one in search of meaning” (1973:5). Margaret Lock has stated:

Cultures, including those of industrial-capitalistic societies, form systems of meanings which provide explanations of how the world works, of what is thought of as “real” and what is designated as “natural” and inevitable. These meanings link people to one another and form the basis for social action (1988:5).

Thus the meanings individuals, as members of a culture, use to interpret their reality are learned as a result of the interactions and relationships encountered within the sphere of their socio-cultural environment. That is, our perception of the physical reality out there, and our sense of what is real is a product of culturally determined values, attitudes, beliefs and associations. In order to grasp the reality of others we must examine culturally derived meanings that order the events of their lives. It has been stated that “an interpretive social science involves conscious translation across meaning systems to arrive at understanding of the realities of others” (Good and Good 1980:174). “As paintings enable the viewer to sense the visible in a different way, so the ethnographic text
permits the reader to understand the variations of the human experience” (Pliskin 1987: 12).

BACKGROUND

Throughout this thesis I will draw distinctions between individuals and groups holding different perspectives. However, this is done with a sensitivity to the fact that any interpretation is itself the product of a particular perspective. Therefore I begin by contrasting my perspectives with the writings of other researchers in this area. The literature introduced here will be followed up more thoroughly in the second chapter. This is followed by a discussion of several cultural differences between Americans, Japanese, Koreans and Chinese which are illustrative of the vastly different cultural realities held by American medical professionals and Asian international students.

CONTRASTING PERSPECTIVES

Enrollments of international students have grown dramatically in the United States over the last several decades, from less than 10,000 in 1930, to more than 407,529 during the 1990-91 academic year (Sanford 1987; Fortune 1991) Along with the increasing number of international students on American college campuses has come an increase in the recognition of their distinct medical needs and health concerns. The manner in which international students cope with American culture and its medical system has been examined by many health care providers over the past three decades (Ichikawa 1966; Ray 1967; Huang 1977; Vogel 1986; Sanford 1987; Burack and Knorr 1990).
One early study identified a foreign student syndrome, characterized by students who ... “expressed somatic complaints, regression to an oral aggressive dependence, a passive withdrawn attitude, and a marked reluctance to converse” (Ward in Ray 1967:363). This initial study stimulated interest which led others to join in further scrutinizing this group of students. In a survey conducted by physician-researchers the visitation rates of international students and domestic students to the college health service, infirmary and local hospitals were compared. They concluded that international students demonstrated an increased visitation rate compared to domestic students (Ray 1967; Maha in Sanford 1987). Special medical problems of international students were reported in work by Dr. Mary Ray, who cited the “need in many college health services [for] a common resource to aid in identifying suspected exotic disease” (Ray 1967:361). Alice Ichikawa reported on experiences with foreign students at the University of Chicago Student Mental Health Clinic. She recounts two dramatic cases; in one, a student quits school and leaves the country and yet she claims these cases “...do not, as seen in our clinic, demonstrate unusual ways for students to deal with their problems” (1966:183).

Twenty years after the initial description of a foreign student syndrome, Zwingmann and Gunn described what they called uprooting disorder. The list of symptoms characterizing this disorder included “... feelings of isolation, powerlessness, alienation, and disorientation as well as hypochondrial reactions” (Sanford 1987:103).

Other investigators have continued to explore the barriers to health care facing international students (Ebbin and Blakenship 1984; Sanford 1987). More recently attention has focused on the challenges facing international students and their families as they participate in American
academic and social life (Huang 1977; Jensen & Jensen 1983; Vogel 1986). Health needs assessments have been conducted by several universities in an ongoing effort to facilitate health care to this special segment of the student population (Ogbudimkpa et al. 1988).

These studies have been conducted primarily by medical-researchers whose general aim has been to familiarize other health care providers with the unique medical problems and health care utilization patterns of international students (Sanford 1987).

Observing accepted biomedical tradition these studies have been quantitative, objective and analytical. Mute to the voices of students, they are strongly biased to research methodologies that are necessarily reductionist, and result in labeling syndromes, detailing disease, and tabulating infirmary admissions.

In contrast, the qualitative approach used in this thesis project will fill a gap in the literature by allowing students to identify the issues that concern them. This approach not only opens the door to exploration and discovery but breaks down the barriers between researcher and subject so that we might, “regard our fellow humans as people instead of subjects, and regard ourselves as humans who conduct our research among rather than on them” (Wolcott 1990:19).

This study does not allow for broad generalizations about this group of students. It was not designed along the lines of a hypothetical, or model based inquiry. The informant group was small, and the interviews were informal and open-ended. My goal was to listen to what these students had to say about themselves and their experiences and in this way gain insight into their reality.
A meaning-centered or interpretive medical anthropology approaches sickness not as a reflection or causal product of somatic processes but as a meaningful human reality (Good et al. 1980:174).

CONTRASTS IN CULTURE

In the remaining pages of this first chapter I will contrast, in general ways, some of the cultural differences between the United States, Japan, Korea and China. However, in drawing these distinctions, it is worth remembering that there are no simple formulas for describing the lives of individuals. My intent here is to side-step complexity in favor of presenting some broad generalizations as an orienting mechanism for understanding the differences that exist among these groups. However, that said, I also recognize that exceptions will always be found among different groups and even among people of one group. For in the lives of real people in real places and settings, there are, of course, similarities overlapping differences along with a host of other ingredients that combine to formulate the basis of human experience.

Regional, familial and other influences add local color to human social groups. Ultimately however, they hold in common some culturally identifiable values and beliefs; “because people cannot act or interact at all in any meaningful way except through the medium of culture” (Hall 1969:188). Thus, social researchers recognize that by comparing generalized cultural norms they are able to attain a deeper level of understanding, since “...a majority of the people of each society do act according to their society’s accepted and usual patterns of behavior in their day-to-day business of life” (Hsu 1985:2).

There are innumerable ways culture is manifest in our daily lives; child rearing practices, language and patterns of communication, spiritual
and philosophical traditions, to name a few. In the following pages I will examine some of these practices as illustrated in American, Japanese, Chinese and Korean cultures.

CORE VALUES AS A CLUE TO CULTURE

American Individuality

The cultivation and expression of individuality is a hallmark of American culture, and is fundamental to the modern epistemology of the West. "La personne morale, as Mauss phrased it, is the uniquely Western notion of the individual as a quasi-sacred, legal, moral, and psychological entity whose rights are limited only by the rights of other equally autonomous individuals" (Lock and Scheper-Hughes 1990:57). From the perspective of most Americans this idea seems unremarkable. However, this concept of individuality that places the person in opposition to society is a fairly recent development and unique among the cultures of the world (Lock et al 1990:57). Taking a historical perspective Hsu attributes this characteristic, in part, to the self-reliance of American pioneers, the revolutionary political separation from the English, and a tenaciously held belief in equality. Further, he points out that even our homes are arranged so that, "space and possessions are individualized" (1985:78).

Childrearing Practices

The encouragement Americans give their children to be independent is an expression of this strongly held value. Child developmentalists encourage parents to teach children self-responsibility through self-choice. They emphasize allowing children to experience
natural logical consequences. For example, instead of arguing or forcing a child to wear a jacket outside who doesn’t want to, they may let him go without it, believing that he will get cold and next time will remember to put the jacket on himself (author’s personal experience). Americans expect their children to learn how to cope without them at an early age and the crying of children being left at daycare or nursery school is coolly explained in developmental jargon as separation anxiety; an accepted stage in the process of growing up.

Modern psychologists and psychoanalysts have tended to interpret the process of individuation, defined as the gradual estrangement from parents and other family members, as a necessary stage in the human maturation process. This is, however, a culture bound notion of human development (Lock et al 1990:57).

These patterns of parenting lie in stark contrast with those of Japan, where “parental dependency is fostered” (Doi 1986:125). However, this is not to say that the Japanese encourage mother-child dependency. They wean children from mothers as do Americans. However, rather than encourage individualism, the Japanese encourage the development of relationships with others; in particular those with teachers and especially peer groups (Rosenberger 1993). Nonetheless, Japanese mothers take great responsibility for their children’s emotional development. In fact this may pose difficulty for Japanese mothers in the U.S.

One young modern mother who wanted to take quilting classes for herself in the mornings felt great pangs of guilt as she saw her child’s sad face through the window of the daycare center as she left. She worried that his development as an emotionally secure individual might be hampered, and then she worried that if he did adjust to this individualistic American society, maybe he could not fit into Japanese society upon return! (Vogel 1987:278).
Furthermore, this notion of dependency is characteristic of Japanese
culture where, “this behavior pattern is even institutionalized into its social
structure, whereas perhaps the opposite tendency prevails in Western
societies” (Doi 1986:125). A common Japanese word that expresses the
notion of dependency is *amae*.

*amae* is the noun form of *amaeru*, an intransitive verb that
means, “to depend and presume upon another’s benevolence”. This word has the same root as *amai*, an adjective that means sweet. Thus *amaeru* has a distinct feeling of sweetness and is
generally used to describe a child’s attitude or behavior toward
his parents, particularly his mother. But it can also be used to
describe the relationship between two adults, such as the
relationship between a husband and a wife or a master and a
subordinate (Doi 1986:121).

**Mechanisms of Social Control**

Ours is a culture that values social autonomy, we “…love
independence and individuality…and rebel against the constraints of a
hierarchical, interdependent society” (Vogel 1986:275). In American
culture, where the autonomy of the individual is valued over social
harmony, mechanisms of social control tend to be imposed from the outside
through law. W. T. Jones suggests an Asian opposition to this propensity
when he refers to, “the Chinese hostility to positive law derived deductively
from an abstractly and explicitly formulated code” (1976:396). Lin Yutang
further illustrates the point:

As a people, we are great enough to draw up an imperial code,
based on the conception of essential justice, but we are also
great enough to distrust lawyers and law courts. Ninety-five
per cent of legal troubles are settled out of court (Yutang

Americans joke about lawyers and complain about litigiousness and
yet in the absence of social contracts governing relationships it appears we
are increasingly dependent on this complex legal webbing as a means of maintaining social cohesion and individual protection.

American individuality is in pointed contrast to the relationality of Chinese and Korean cultures, which share a tradition of Confucianism still influential in contemporary thinking. Family relations offer one example of this,

Familial relations provide a model for social behavior. Respect your own elders, as well as others' elders; be kind to your own children and juniors, as well as those of others. For this reason the Confucian society regards itself as a large family--"Within the four seas all men are brothers--" (Kung and Ching 1989:69-70).

Hsu talks about the Chinese ideal of mutual dependence, and refers to, "reciprocity as a social contract" with a life long obligation (1988:114). In Korea as well, "Feelings of mutual responsibility among family members have traditionally been very strong. They outweigh responsibilities of neighborliness..." (Macdonald 1990:70). Japan has been characterized as "a very closeknit, interdependent society where social harmony and welfare of the group are valued, and valued more than personal wishes or individual realization" (Vogel 1986:275).

Religion and Philosophy

The philosophic traditions of the major Asian religions foster feelings of identification with nature, and a detachment from earthly desires.

In the fifteenth century Zen monastery garden of Ryoanji,...viewing is an emotional experience. One is overcome by the order, serenity, and the discipline of extreme simplicity. Man and nature are somehow transformed and can be viewed as in harmony (Hall 1969:153).
These traditions discourage the development of a highly individuated self (Lock et al. 1990). In contrast to this, Enlightenment thinkers in the West objectified nature. Nature became "...a thing-in-itself --neutral, indifferent to human purpose and to human relationships" (Gordon 1988:24).

Finally, MacDonald comments on the concept of holism with regard to Korean philosophy.

Human nature was also perceived as a continuous whole. A person's feelings as well as mental processes were an essential part of decision and action. Moreover, contemplation---drawing upon one's whole being for guidance---rather than Western-style reasoning was a basis for decision and action (Macdonald 1990: 81).

Patterns of Communication

Communication patterns are another area that mirror cultural values. In the U. S. "...we value highly---clarity of expression, asking for what one wants directly, and negotiating openly and honestly..." (Vogel 1986:275). Americans expect openness---putting all the cards on the table; to be up front with someone demonstrates integrity. Historically, we so strongly valued freedom of expression that we institutionalized it in our constitution.

If a direct form of communication ensues from the valuing of individuality then it follows that the valuing of interdependence and social harmony necessarily leads to less-direct forms of communication that promote social harmony. Harumi Befu in his essay "Ethnography of Dinner Entertainment in Japan", examines the Japanese preference for implicit communication or what Vogel (1986) terms as indirect communication. Befu states,
...an intriguing part of the cultural assumption operating in this context... is that both hosts and guest are supposed to say what they do not mean... In sum, then, face to face interaction is like a drama, in which each actor knows what the others are supposed to say. Part of what this means is that multiple meanings of expressions are correctly sorted out by the participants and behavior appropriate for each meaning is acted out in appropriate contexts (1987:110-111).

In comparison with the American pattern of directness, the Japanese expectation of implicit communication appears subtle and to some deceitful when they fail to perceive the operational context. "The occasions when Japanese are so subtle and indirect in conveying their wishes that Americans do not catch their meaning at all are too numerous to mention" (Vogel 1986:276). Subtlety then, reflects the contextual nature of Japanese social interaction, where shifts in expression occur with situational changes. It is understood that individuals will act out the appropriate role within the social relationship; this is sometimes referred to as social relativism. In practice, an individuated self must be suppressed in favor of dependency and conformity. However it has been stated, "...a fear that haunts many contemporary Japanese:[is] that of losing oneself completely, of becoming totally immersed in social obligations" (Lock et al. 1990:57). Lock further suggests that, possibly as a defense, the Japanese distinguish between an inner more private self and an outer or external self. These distinctions are embodied in language. The words tatemae and honne meaning "surface" and "inner feeling" along with soto and uchi meaning "outside" and "inside", clearly express the multi-layered perspective of Japanese culture (Lock et al. 1990:57).

Jones acknowledges the notion of implicit communication, when he refers to "untaught teachings or "wordless edicts" (1976:397).
He maintains that in a social setting where people are “mediately related” that is, individuated,

...there will be an emphasis on verbal exchanges---on taught teachings, as it were. But the immediacy-bias leads to an opposite perception of human relations...untaught teachings and wordless edicts will seem both possible and desirable. Hence the frequent reference in Chinese thought to spontaneous cooperation, in contrast to command (1976:397).

The N-Configuration and The G-Configuration

W. T. Jones provides another way of understanding these differences between Americans, Chinese and Japanese cultures. In his essay he develops a model of two world views, a G-configuration and an N-configuration.

The N-configuration he states,

...emphasizes broad general characteristics, is experienced from the outside, has a preference for the unchanging, and an emphasis on sharp distinctions, on ideal types and on encapsulated atomistic entities (1976:385-386).

Whereas the G-configuration,

...has a preference for the changing, an emphasis on interrelatedness, contextuality and on degree-difference, an emphasis on the uniqueness of each individual object, and is lived through or directly experienced (1976:385-386).

In essence, the N-paradigm typifies an abstract-bias, while the G-paradigm typifies a concrete-bias. He maintains that these two world views, and others, are conspicuous in Western science although the N-configuration has predominated. Additionally, he suggests that a scientist’s “way of doing science reflects his notion of what science is” (1976:391). In affirmation of this, he proposes we simply listen to how some
social scientists talk about roles and statuses, while others discuss rules and norms.

Talk about roles and statuses emphasizes that individuals must adjust to roles and fit into statuses; the roles and the statuses are perceived of as independent of the individuals who "play" and "occupy" them. In contrast, talk about rules and norms focuses attention on the fact that roles and statuses are internalized and individualized. This language emphasizes that what is important is the various ways in which concrete individuals play the same role (1987:389).

In addressing this concept with regard to the concrete-bias of Asian cultures, Jones, citing Joseph Needham (1970), states:

Taoism inculcated acceptance of Nature and natural phenomena. ...Chinese parents adopted an attitude of extreme permissiveness in the house training and home life of young children. From the beginning the supple and personal relations of li were felt to be preferable to the rigidity of fa. That is, law administered [by men] paternalistically, judging every new case on its own merits was preferred to the notion of these judgments as being derived deductively from an abstractly and explicitly formulated code (1976:396).

Restated, the emphasis on contextuality characteristic of Japan, Korea and Chinese cultures permits the development of a relative ethic in which the meaning of right and wrong are situationally determined. Conversely, a Western emphasis on the abstract leads to development of an absolute ethic, in which right and wrong are clearly delineated and unchanging regardless of the context. Superficially this would seem a simple proposition and yet in reality, or concreteness as Jones would put it, idealized assumptions that appear black and white rapidly fade to shades of gray. The American struggle over gay rights and abortion highlights perfectly the paradox of applying a discrete, abstractly derived code of behavior to vastly complex real-life situations.

In conclusion I would like to specify pairs of words that further reflect the contrasts I have drawn above: individuality vs. relationality;
absolutist vs. relativist; implicit vs. direct; holism vs. dualism; and internalized norms and rules vs. an emphasis on roles and statuses. These dualisms can be subsumed further under the general categories of rationality vs. intuitiveness, competition vs. cooperation and science vs. spirituality. Throughout the following chapters I will draw on these differences, not to acclaim one above the other, but to use them as a framework for interpretation and to see ways in which these dualisms are significant in medical encounters and ways in which they are challenged.
CHAPTER TWO

LITERATURE REVIEW

The language of medicine does not merely describe a pre-existing biological reality, but instead creates its own objects of analysis (Lock 1988:4).

In this chapter I will review literature relevant to the thesis. I have divided the information into two broad domains. The first section surveys literature written by clinicians or medical researchers and is centered around a biological and biomedical paradigm used to describe health care issues and international students. The second considers the cultural and theoretical writings of anthropologists with particular regard to alternative ways of understanding health, medicine and the scientific paradigm.

Part I: MEDICAL RESEARCH LITERATURE

The literature written by physicians and other university health care professionals evaluating the issues of medical treatment and adjustment challenges of international students falls into two broad categories; some are oriented toward the Western biomedical model (Ichikawa 1966; Ray 1967; Sanford 1987; Zwingmann and Gunn 1988; Ebbin and Blankenship 1988), while others take a more student-centered approach (Huang 1977; Williamson 1982; Jensen and Jensen 1983; Vogel 1986).

A medicocentric worldview channels “...experience through medical filters in which the medical view is reality” (Kleinman in Piferling
In this section I will attempt to demonstrate the medicocentric perspective of many medical researchers, including those who operate under the perception of cultural sensitivity. Furthermore, I question whether "facts" uncovered during the course of research reveal an objective portrayal of evidence, or rather, are a reflection of the researcher's underlying worldview. A vast majority of the literature published describing diagnoses of foreign student syndrome and uprooting disorder either disregard or misunderstand the role of culture and thus implicitly portray international students in an unfavorable manner.

Foreign Student Syndrome

At a meeting of the American College Health Association L.E.Ward presented one of the earliest and most influential papers on health and international students (Ray 1967). In it he described for the first time a foreign student syndrome characterized by:

...somatic complaints, regression to an oral aggressive dependence, a passive withdrawn attitude, and a marked reluctance to converse. In more severe cases, the symptoms mentioned above are accompanied by a general disheveled appearance and a restriction of body movements (Ray 1967:363).

As will be seen in the following discussion Ward's characterization of international students has been frequently utilized by others and perpetuates what I understand as a medicocentric stereotype that conveniently (for physicians) subsumes these students under a label and obscures any comprehension of their illness experiences.

In 1966, Alice Ichikawa recounted at the 44th annual American College Health Association some experiences of the University of Chicago Student Mental Health Clinic. During the 1965 academic year the clinic saw seventeen of the five hundred foreign students on campus at the clinic.
Ichikawa provides "...examples typical of the way in which different foreign students state their problems" (1966:182). They differ from Americans, she says, "only in the frequency with which they state physical complaints and express expectations for relief from physical symptoms" (1966:182). Following this introduction she reports on two cases that she claims are "not unusual ways for students to deal with their problems" (1966:183). One case involves a 32 year old graduate student from India who, according to Ichikawa, chooses to focus on a single physical symptom as the basis for his problem rather than admit that "overwhelming circumstances" are creating his health problems. A second case involves a 32 year old Japanese student who, "regressed to a dependent state, openly expressing his need to be taken care of" (1966:183). The outcome of her analysis hinges on the importance she assigns to the fact that the Indian student, whom she claims was unable to overcome his crisis, because he had a problem at home that still concerned him after his arrival in the U.S. She concludes, "From our experience, it is apparent that foreign students who have had extensive problems in their own countries are more vulnerable to stress here than those who have managed without too much difficulty at home" (1966:185). She also states that those in the latter category generally are able to "take hold and adjust" (1966:185). Ichikawa leaves unaddressed such statements as, "those who have managed without too much difficulty at home", and why the student described as having "regressed to a dependent state" also had "spurned the idea of psychotherapy" and was seen as "unable to overcome his crisis".

We see this sort of characterization again in the following statements by Dr. Mary Ray presented at the same conference
The foreign student syndrome...came to my attention recently when...this student who usually looked like a character one might see on the fashionable boulevards of Rome or Paris appeared on this occasion like the perfect candidate for referral to the mental health clinic (1967:363).

She further dramatizes issues of foreign student health with stories of “...unexpected exotic or fatal disease discovered in Evanston...” (1967:361). Additionally, she seems to question their honesty and intelligence with the following statements in her introduction.

The day has almost passed when the competent tuberculosis scholar might purchase a normal chest film in order to satisfy his requirements for admission to the United States...only [to learn] that the rascal in the bazaar had sold him the chest film of a healthy female (1967:361).

The presentation of these papers at professional conferences served to further entrench a narrow medicocentric perspective regarding international students and health care within the university medical community. While most of us today, sensitized to what is often called politically correct thinking of the 90’s, may excuse these early articles as uninformed, they nonetheless illustrate a feature of the biomedical model as it is practiced.

A product of Western scientific thinking, the biomedical model simplifies differences among individuals in order to subsume them under labels such as foreign student syndrome. This legitimized the problems physicians were having to cope with by utilizing a clinically defined illness reality pertinent to Western medicine. It also however, disregards the role of culture; for it may be the case that “a passive withdrawn attitude” is reflective of a student taking the “proper attitude” toward a clinican whom he recognizes as his superior.

Rooted in the abstract, Western scientific thought “...has no interest in individuals as individuals; one is simply interested in the abstract
generalizations that may be found to characterize a group of subjects in differing situations" (Jones 1976:386). When health professionals adopt the perspectives of their peers and training, labels like foreign student syndrome prove a legitimate and convenient manner of coping with students bringing new traditions and practices with them to university health care settings.

This proves particularly true when students are thought to deny the real basis of their problems choosing to focus “upon a single physical symptom as the reason for [their] inability to function” (Ichikawa 1966:183). The tendency to use the body as a metaphor to signify one’s feelings is called somatization. The dilemma here is “...that somatizing patients put physicians in a double-bind ...rendering them simultaneously powerful and powerless” (Pliskin 1987:11).

Typically American university health centers are not structured to cope with this; physical ailments come under the attention of doctors and nurses while psycho-emotional complaints are directed to the care of mental health experts. Since “for the most part, psychosomatic disorders have been incorporated into biomedicine as a class of not quite legitimate illnesses best handled by mental health practitioners” (Kirmayer 1988:64).

If we contrast somatization, representing interrelatedness of mind and body, with the biomedical model representing duality of mind and body; then clearly somatization, as a culturally constructed concept of illness, does not fit the Western biomedical paradigm, particularly as it is institutionalized within the structure of health care system.

The notion of a foreign student syndrome had a lasting effect on the ideology of some practitioners in the university health care scene. Twenty years after Ward described the foreign student syndrome, Zwingmann and
Gunn (1983) described what they called “uprooting disorder”. They report the symptoms of this disorder as including “... feelings of isolation, powerlessness, alienation, and disorientation as well as hypochondrial reactions” (Sanford 1987:103).

Pliskin has suggested that labeling may emanate from the doctors need for exoneration from blame;

The therapists misinterpret and misdiagnose their patients since the categories they use are pertinent to Western culture. Both therapists and patients are frustrated by the clinical encounter, and therapy fails. Thus [labels are] vindication for the clinicians with blame on the patients (1987:11).

Furthermore, she maintains that these diagnoses are an attempt “to pretend to know, when they don’t, to not assume responsibility for an illness that is a cultural and social construct, to transfer responsibility for failure to the patients, to divorce themselves from the enigma of doctoring”(1987:12).

Continued Support for Old Ideas

As recently as 1987 new labels for an old ideology continue to surface. Although Alexander Gunn, in his essay “Health Care and Foreign Students”, is careful to qualify his statements with a disclaimer on the problems of labeling migration and mental illness, he nonetheless proceeds to delineate “a few of the major but inescapable consequences of uprooting " (my emphasis) (1988:347). Once this notion of uprooting is introduced, Ebbin and Blankenship reinforce the idea by maintaining that their study conducted at University of Southern California “revealed barriers to health care, supporting the foreign student syndrome and uprooting disorder established by previous investigators”(1988:311). However no explanation was forthcoming on how barriers to health care and these diagnoses were
related. Additionally, they confirm earlier claims of higher frequencies of stress-related diagnoses made for foreign students than domestic students. They conclude that “foreign students do use the student health services more frequently and are more prone to stress-related somatic complaints” (1988:311).

Although these findings seemingly reinforce the conclusions of previous researchers, not all researchers agree. Allen and Cole (1987) in their article “Foreign Student Syndrome: Fact or Fable?” begin by questioning the methods used to establish evidence for these claims. Stating,

The evidence for the very existence of foreign student syndrome rests largely on case history material. The first description by Ward consisted entirely of case histories and Gunn’s discussion of foreign students contained only one reference to statistical data---on mental illness among French students... (1987:183).

Furthermore, they maintain “...if Ward and Gunn were correct, then foreign students could be expected to consult more for conditions classified under the International Classification of Disease” (1987:183). However, they maintain their findings suggest that most physicians believe that psychological causes are the main reasons for consultation among this group. They evaluate the foreign student syndrome using statistical analysis to test their hypotheses that consulting patterns of foreign students would be no different than domestic, and neither the frequency nor pattern would differ between these groups once age, sex and distance from residence to health service were controlled for. They maintain that their results suggest a foreign student syndrome does not exist, and in fact “...it even seems that emigration improves health” (1987:185). Although it is encouraging to see a study that refutes the notion of a “foreign student
syndrome”, again I find this work relies on a starkly analytic view and no mention is made of the socio-cultural dynamics that prominently figure into individual illness experiences.

The overall significance of this literature lies in a reexamination of its initial propositions linking health problems of international students to an abstract model of disease. First this clearly demonstrates how the abstract-bias of Western scientific worldview can simplify differences among individuals in order to combine them into members of a class, to which a discrete, abstractly derived code of behavior can be applied (Jones 1976). A practical effect of this, as suggested above, is that it allows physicians to use a convenient method of coping with an otherwise frustrating problem, and at the same time alleviates them from blame for failure. Furthermore, labeling a syndrome illustrates the lack of clinical relevance culture has in the medical setting; particularly with regard to its effect on the clinician’s own perspectives and perceptions of health issues concerning international students. Finally it denotes the inequalities inherent in a medical system which has bounded itself with the dominant medical paradigm and holds little regard for other culturally accepted beliefs of health and illness.

However, the real question is; whose reality is it these authors are describing? Do international students actually suffer from a some sort of “syndrome”, or is this diagnosis the reflection of a biomedical paradigm ill-equipped to cope with other culturally defined beliefs regarding health and illness?
Epistemology-Free Social Science

Clearly, a reductionist analysis of the body-machine does not provide a complete picture of human problems. However even social scientists may fail to shed new light on old problems if they suspend scrutiny of their own beliefs. Mary K. Sanford's essay, "On Being Sick Away From Home: Medical Problems and Health Care Needs of International Students" claims to "...illuminate and provide anthropological perspectives on two aspects of international student health care" (1987:102). Using a number of case histories from African and Latin American students, she intends to present the students' perceptions of their problems, show why they may be reluctant to comply with medical instructions, then seek to illustrate how subtle cultural differences can lead to misunderstandings between doctors and patients.

Sanford's approach at first promises a change from those of previous researchers as she intends to present the students' perspectives. However, she couches her discussion amidst case histories and she only occasionally uses the actual words of the students. Certainly it is to be expected that authors, of necessity, will include some amount of narration and description throughout a document. However, when the student's descriptions of their experiences are left out, we again face the question of deciding whose reality is being described? For example, the author describes the following case as "a classic example of the relationship between physical symptoms, emotional problems, and uprooting crises..."

Joshua, a 28 year old Igbo, has been studying in the United States for two years. Soon after his arrival, he became very worried about his future and his school work. He began to suffer from insomnia, fatigue, restlessness, and loss of appetite. Eventually, he found it difficult to function socially or academically and he secluded himself from others. When he began to run a fever, he visited a specialist in the local medical
group. The doctor ran a series of tests which all proved to be negative. The doctor told him that while there was nothing physically wrong, he needed to relax and socialize more with others. The student followed the doctor's advice and found that after 4-6 months he started to feel like himself again (Sanford 1987:106).

Clearly Sanford's retelling of this experience typifies the Western scientific perspective which presumes that Joshua, and the elements of this experience that had meaning for him, are unimportant in understanding the situation. Consequently, she fails to explore Joshua's thoughts and feelings about this experience, and additionally she provides a retelling of events oriented solely around the doctor-patient relationship and not the rest of his life as a part of the healing process.

Sanford concludes that her results "...further substantiate the existence of a link between cultural adjustment difficulties, and the development of health problems among international students" (1987:106). Thus she ends up placing responsibility for adapting to differences in health care norms with the students rather than the clinicians. She calls for educational programs designed to teach the students about the system.

...organization and procedures of the health care system...adequate preparation will allow students to frame more realistic expectations of the American health care system and be less likely to experience unpleasant surprises when they attempt to find medicinal help. (1987:116).

The obvious yet implicit message behind this statement reveals the belief that a health care system does not bend to meet the needs of people, the people bend to meet the needs of the system. This inflexibility, in effect, serves to maintain the hierarchy of power institutionalized within the structure of the health care system. Furthermore, it demonstrates the abstract-bias of biomedical ideology which objectifies and thereby de-contextualizes individuals from their socio-cultural foundations.
Finally, this article is vivid in its portrayal of how underlying worldviews influence perceptions. Sanford, while hailing the "...unique, biocultural perspective [of] anthropologists [as] ideally suited to address these complex and sensitive issues" (1987:117), fails to recognize her unquestioning acceptance of biomedicine as the standard of medical models.

Allan Young has characterized the unquestioning acceptance of ideas as epistemology-free social science.

When this happens, and epistemological scrutiny is suspended for Western social science and Western medicine, empiricist-leaning anthropologists are free to adopt, as part of their own conceptual apparatus, the conventional wisdom of the dominant medical culture of their society (Young 1982:260).

If we are to conduct comparative studies we must first become aware of our own cultural biases and "...free ourselves from the illusion that Western medicine is true and that other views, to the extent that they deviate from ours, are false" (Jones 1976:403).

New Perspectives on Old Problems

In contrast to the previous article Suzanne H. Vogel's (1986) goal is consciousness raising. Recalling her own struggles living as a foreigner in Japan she feels that upon close examination of a culture "...radically different from ours--we can increase our understanding of cultural differences and of what happens when people from one country try to live and function with a very different society" (1986:274).

In her case study of Japanese wives and families who have accompanied their husbands to school at Harvard, she provides compelling insights into the nature of the cross-cultural experience.
While dealing with issues of language, social isolation and other dilemmas of living overseas, she also illustrates how the lack of shared meaning contributes to the problems.

...sometimes what is labeled a language problem is really a problem of cross-cultural communication. As one Japanese man explained to me, he understood the words but not the meaning. And the meaning usually lies in the social context or the interpersonal relationship (1986:275).

She contrasts the Japanese preference for silent understanding and indirect communication with Americans emphasis on clarity of expression and asking for what one wants directly. Then she demonstrates how these cultural norms translate to reality by relaying a story about an American obstetrician and a Japanese mother. Vogel was called on to translate by the obstetrician, although it turned out that the Japanese mother not only spoke English but she was also a medical doctor. The problem arose when the obstetrician told the woman she had to decide on a pediatrician soon so he could come to the hospital to examine her premature baby. The mother would remain silent when faced with choices of health plans and pediatricians. She and her husband had little understanding of our insurance system and no basis for choosing a doctor.

But more than that, this mother was stunned that the obstetrician asked her to choose a doctor. Her assumption was that the doctor caring for her would wisely choose a pediatrician for her baby. Surely this obstetrician could understand, without being told, how difficult it would be for Japanese newcomers to make their way independently through our health care system (Vogel 1986:275).

Furthermore, in contrast to previous suggestions that more education and explanation are needed to facilitate delivery of health care, Vogel states: “Health Service efforts at education and explanation do help them find their way ...but still they are probably underutilizing our
services” (1986:278). She concludes with some very practical and poignant advice:

...I think that all of us who deal with Internationals on our campuses need to remind ourselves that living in a foreign country is always stressful and that many adjustment problems are inevitable and normal. We need to realize that some of our very basic assumptions...may not apply to other peoples. We need to keep our minds open...and continually expand our awareness (1986:279).

Along with Vogel, others have recognized the need for a more sophisticated and culturally sensitive approach (Huang 1977; Jensen and Jensen 1983; Williamson 1982). Ken Huang provides an informative and culturally sensitive look at international students in American universities. He proposes some of the challenges facing these students include: “(1) communication barriers, (2) shifting cultural gears, (3) replacing a support network, and (4) multiple accountability” (1977:216). At the same time he holds accountable the universities who “appear positive but passive in their attitude toward foreign students” (1977:217). Huang astutely recognizes that in times of declining enrollments and increasing costs, “foreign students have become increasingly important consumers and a source of revenue. Some have called this domestic colonization. The colonizers are said to care for their purse, not the student’s welfare” (1977:217).

Huang creatively portrays campus life macroscopically, as mirroring the outside world, and microscopically, as a symbiotic community composed of faculty, staff and students. In recognizing these interrelationships, it follows that he advocates a multi-level, multi-dimensional design for mental health intervention as the best immunization against psychosocial disorders. While I find Huang sensitive to issues challenging international students, caution is advised in
his linkage of psycho-social disorders and international students; subsuming individuals into neatly defined categories treads the edges of what could be called the syndrome mentality.

Ken Huang's article is important for several reasons. First, it is sensitive and revealing in its treatment of the many challenges facing international students and unique in its approach to solutions. Second, he argues for a framework that embraces a micro and macroscopic view of community. Finally, based on mutual respect and collective well being, his views clearly advocate a holistic approach to dealing with this issue.

The essay illustrates the influence of cultural perspective in doing science. That medical practitioners choose to subsume international students under a label, that obscures if not all together ignores individual differences, is typical of the Western biomedical paradigm that favors the utilization of simplified diagnostic categories. Huang in his own words values a “system based on cooperation, collaboration, mutual learning, and mutual assistance....[that] comes closer to preparation of the whole man, not just his mind, but body, heart and soul” (1977:219). Drawing again on W. T. Jones “...our worldview does make a difference in the methods we use and in the conclusions we reach...” (1976:394).

While some researchers make no reference to culture at all, others achieve varying degrees of success, (Ichikawa 1966; Williamson 1982; Sanford 1987; Burak and Knorr 1990; Alexander and Shaw 1991). Often medical researchers demonstrate a shallow understanding of culture. The following example illustrates the problem.

First the author acknowledges culture as a factor in cross-cultural health settings,
...there are cultural differences which have some bearing on the way in which foreign students present themselves. From our clinical impression the more different their country is from ours, the greater the problems of adjustment and the greater the difficulty they experience when they run into a situation with which they cannot cope (Ichikawa 1966:185).

This is followed however with the claim that the factors influential in health problems are not very different for international students than they are for American students.

In our experience, the psychodynamic factors involved in the crises of foreign students and their amenability to help are not very different from the factors involved in the crises of American students (Ichikawa 1966:185).

Clearly these statements contradict one another and reveal a shallow understanding of the role of culture in the health care setting.

It is conceivable that a medicocentric perspective may impede treatment and/or damage the doctor-patient relationship. Dr. Mary Ray while treating a Moslem student observing Ramadan, who was having stomach problems, informs him that his religious fasting “...was not a productive form of self-castigation” (1967:364). Though used earlier, the following description also provides a striking example of how the biomedical perspective becomes a standard against which all other events are judged.

...normally looking like a character one might see on the fashionable boulevards of Rome or Paris...came to the clinic unusually unwashed and rumpled, ...appearing on this occasion like the perfect candidate for referral to the mental health clinic (1967:363).

Williamson addresses some of the problems that arise when health professionals assume “that one’s belief’s and one’s ways of providing health care are correct and superior...” (1982:189).

In reference to stereotyping she states,
...expecting that all think, believe and behave in the same manner...greatly interferes with the provision of individualized, adequate health care... the failure to recognize culturally elicited behaviors may lead to non-compliance with treatment (1982:189).

She also recognizes that “students bring with them their own ideas, beliefs and health care practices which may be quite different from the norm in the typical American university” (1982:189). All of this can be compounded by language barriers and illnesses not commonly encountered by American health care providers. In some cases repeat visits for multiple physical symptoms, Williamson states, can lead “to difficult and frustrating health care experiences for both the health care provider and the student” (1982:189).

She asks how the treatment process might be improved to create a more satisfying experience for providers and students. In answer, she offers several practical suggestions that she and her colleagues have found helpful in their clinic. These include:

...attention to the student as an individual and recognition that his cultural background affects his health behavior are for most. Ask, ‘What would you do and how would you be treated if you had these symptoms in your home setting?’

If a serious language barrier exists, an interpreter should be present to insure clear communication.

A written plan of care should be provided. This may be in outline form, using short simple phrases and words (1982:190).

This short, pragmatic article promotes multi-cultural health care by elucidating factors that impede the treatment process, and recognizing that both health providers and students share responsibility for effective communication.
Perhaps the most significant aspect of this article, however, is the emic, or insider view, she shares in the following stories:

Not only is there poor communication when student and provider speak different languages, there is often inability to discuss concepts such as stress or depression. In this case, the temptation is to provide a prescription for medication without explanation or other therapeutic intervention. Or one may say, ‘There’s nothing wrong with you without discussing possible cause of symptoms’.

When students repeatedly visit the health center, each time with a new complaint, the student comes to be viewed as, ‘Oh no, there he comes again’ and the health care provider dispatches the new complaint as quickly as possible.

A Moslem student complaining of upper respiratory infection symptoms included in his history that he was fasting. The health professional snapped back, ‘Fasting? You’re supposed to feed a cold and starve a fever. You shouldn’t be fasting’ (1982:189).

Williamson clearly illustrates the challenges facing both patients and providers in the cross-cultural medical setting, and is one of few clinicians willing to place the responsibility for cultural awareness with the health care providers.

Williamson has demonstrated the need for clinicians to develop cultural awareness as a means of facilitating the delivery of health care to international students. This need however expands beyond the walls of the health care clinic.

Jensen and Jensen (1983) report on what they call the cross-cultural considerations of newly arrived Asian students. Importantly they recognize the opportunities for enrichment inherent in the meeting of Asian students and their American counterparts. They advocate that American students “help them adjust to our ways of class attendance, taking notes, participating in class, meeting deadlines, and taking
examinations" (1983:371). These matters may often be overlooked in the orientation process and can cause many students unnecessary difficulties later as they struggle to cope with class work. In their discussion Jensen et al maintain that Asian students may have a more leisurely attitude toward punctuality than is accepted by American faculty; class participation, another facet of the American classroom, may pose difficulty for most Asian students who "will be shy about participating in the discussion, for they are accustomed to merely listening to lectures" (1983:372). This was a common concern of students I interviewed. Even those who had lived here for many years often felt they could not participate at the level their professors expected of them.

The paper continues in listing a variety of areas ripe for misunderstanding such as idiomatic expressions, referral to study skill centers, gestures, facial expressions and eating habits. The authors make no attempt at analysis regarding the nature of the cross-cultural experience, but that is not their intent. They simply hope to enlighten the academic community to some of the differences in academic and social life international students face, with the hope of avoiding misunderstandings and building bridges. Although this article may be lacking in depth, its value lies in its explicit illustration of culturally specific behaviors and the effect they have in cross-cultural settings where individuals from different cultures envision different realities.

Finally, I have attempted to illustrate how a medico-centric perspective fails to address the relevance of culture in the medical setting. Fundamental differences in the meaning of the illness experience, for international students and health care professionals, are subsumed under a diagnostic labels that at once discount the reality of the patient and
reinforce the inequalities of a medical system bounded by the dominant medical paradigm. However, I have also presented authors who have reached beyond this paradigm to consider issues of culture and offered new ideas to address old problems.

Part II: MEDICAL ANTHROPOLOGY: NEW PERSPECTIVES ON ILLNESS

Medical anthropology offers new ways of thinking about health and illness. In the previous section I considered illness from the biomedical perspective. Here, in preparation for later analysis, I turn to view illness from an anthropological perspective.

Cultural groups worldwide are known to incorporate healing systems into their patterns of beliefs and behaviors. "Medical systems emerge from human attempts to survive disease and surmount death, and from social responses to illness and the sick role" (Romanucci-Ross 1983). The writings of Pritchard (1937), Turner (1967), and other early anthropologists laid a foundation for medical anthropology. However only recently has it blossomed as a unique field of research. Over the last several decades a vast amount of information has been produced. Still, little agreement is found among many of the authors, as the quest for a suitable theoretical framework has tended to produce a broad range of concepts and theories used by anthropologists in their work.

In general, contemporary research in medical anthropology falls into one of two camps: empirical research, which presumes rigorous methodologies can reveal "truthful" representations of facts and the interpretive approach which centers in on the meanings of illness in the larger context of society and culture. Both approaches have inherent limitations and benefits. In the next set of articles I will examine the
interpretive approach as it is elucidated as an alternative to empirical research in the study of health and illness. Importantly these articles seek to blend the realities of biomedicine and individuals with the context of culture and society.

**BACKGROUND**

Recently, Bill Moyer again challenged Americans' belief space in his television series, "Healing and the Mind" (Moyer 1993). In it he explored the prevailing Western biomedical views of health and illness and an emerging new medical paradigm, known as the mind-body perspective. The airing of this program was exciting and indicative of changes taking place in the field of biomedicine that rightly deserve recognition. Even so, it seems the precepts of the biomedical model remain the same. This was illustrated in a review of the series recently published in a popular news magazine. Here the author stated that Western scientists were attempting to substantiate the claims of Chinese healing by applying Western standardized testing procedures to ascertain whether solid evidence existed beyond patient expectations to support this medical system (Newsweek 1993:A4). This obviously implies that the Chinese system of healing is less than credible until validated by Western science. It is precisely this medico-centric perspective that impedes Western medical researchers in their efforts to understand other accepted healing systems.

One possible explanation for this lies, in part, with the lack of epistemological scrutiny in Western social science and Western medicine (Young 1982). "Whereas one can undertake a cultural analysis of
traditional medical systems, biomedicine by its very nature is believed to be privileged and exempt..." (Lock et al 1990:48).

The Interpretive Approach

Margaret Lock and Nancy Scheper-Hughes in their essay, “A Critical-Interpretive Approach in Medical Anthropology: Rituals and Routines of Discipline and Dissent”, recognize that most of the research conducted by contemporary medical anthropologists has taken the empirical approach assuming that it will lead to a, "...truthful representation of the objects or events under study" (1990:48). They point out the lack of sensitivity inherent in this methodology and its inevitable assumption “...that it is theoretically possible to understand the natural world logically and rationally through the application of science” (1990:48), which eventually leads to dominance over nature and mastery of the human body through technology. Ultimately, this means that what is real is defined by measurable physical change; while all other phenomena, ranging from the evil eye to chanting sutras, is considered extraneous (Lock et. al. 1990).

Lock and Scheper-Hughes counter this with a critical-interpretive view stating that:

This approach is part of a much broader movement in which reductionist science as a whole has been subject to a reappraisal, including an examination of the way in which the Western scientific endeavor is a product of specific historical and cultural contexts (1990:48).

This perspective, they maintain, frees medical anthropology to view the biomedical model and other medical systems as culturally constructed. They challenge medical anthropologists to retain a balanced view, recognizing that “The medical anthropologist must tread lightly between
the poles of cultural interpreter and cultural critic, defender of tradition
and broker for change"(Lock et. al. 1990:49). In their analysis Lock and
Scheper-Hughes use the notion of the three bodies, ---the individual body,
the social body and the body politic--- as a heuristic concept for
understanding culture and societies, and meanings of health and illness.

They seek to go beyond culturally sensitive presentations which
attempt to subsume cultural categories under biomedical categories.
Rather, they seek to reveal links between the political and social orders and
physical distress. Noting that:

It is then possible to interpret incidents of spirit possession in
multinational factories in Malaysia, as part of a complex
negotiation of reality in which women factory workers are
reacting to both the violation of their traditional identity and
demeaning work conditions...Or, to relate incidents of
Japanese adolescent school refusal to the larger, national
concerns about modernization and cultural identity...
(1990:70).

This perspective places the illness experience within the larger
contexts of culture and society. It seeks to explain illness as more than an
isolated event or misfortune, but rather as a form of communication. In
this way health and illness are a result of the “interaction among the mind-
body and the individual, social, and body politic” (1990:71).

Ostensibly one might surmise this approach forsakes the individual
for the big picture. Clearly it does not. It is an integrative methodology,
seeking to understand illness within the context of the individual’s whole
environment. In this way it is possible to blend the individual experience of
illness with its contextual framework, and paint a more complete picture of
the whole. In contrast “...reductionist, mechanistic explanations
characteristic of mainstream biomedicine routinely ignore the social
origins of illness problems” (Taussig in Lock et. al. 1990:70).
In his article “The Anthropologies of Illness and Sickness”, Allen Young (1982) reviews methods anthropologists have used to write about illness and healing. In the opening paragraphs he discounts earlier approaches used in studying phenomenological domains and methodologies anthropologists have borrowed from medical sociology. He then focuses the rest of his discussion on the formulation of his ideas which he explains as “an evolving conceptual system centered on the social and experiential particularities of sickness and healing” (1982:261). Young cites the work of Kleinman, Blumhagen, and Good, among others, to evaluate the explanatory model of illness approach. He maintains it is distinctive not simply in its emphasis on the importance of language, which posits all illness as “fundamentally semantic or meaningful and clinical practice as inherently interpretive,” but in its ideology drawn from “the anthropology of ritual and symbol, notably Victor Turner and contemporary hermeneutic philosophers” (1982:262).

An explanatory model of illness is centered on semantic illness networks, which are defined as “the network of words, situations, symptoms, and feelings that are associated with an illness and give it meaning for the sufferer” (Good in Young 1982:263). He further reminds the reader that Good has stated that “semantic illness networks are inseparable from the idea that illness is an individualized process” (1982:264).

Young then describes Kleinman’s explanatory models as “a set of beliefs which contains any or all of five issues: etiology; onset of symptoms; pathophysiology; course of sickness and treatment” (1982:266).
He maintains that Kleinman's notion of explanatory models resemble "Geertz's idea that cultures provide people with ways of thinking that are simultaneously models of and models for reality" (1982:266).

Young argues that explanatory model writers gloss over the social aspects of sickness in two ways. First he criticizes the notion that semantic illness networks are derived from a single set of underlying cognitive structures, namely, explanatory models. Second he objects to a definition of sickness being used as a blanket term covering disease and/or illness. Young defines sickness in processual terms as a way in which "worrisome behavioral and biological signs, are given socially recognizable meanings" (1982:270). He elaborates on his perspective by describing two other ways that people utilize medical knowledge. He calls the first prototypes. These, he maintains, are strings of events and circumstances recalled from the past. The second he terms chain complexes, which he defines as "empirical events, sensations, and symptoms which cohere and persist in the mind" (1982:273). These prototypes and chain complexes he maintains, go beyond explanatory models and semantic illness networks to further define the meaning of sickness.

A final and noteworthy segment of this essay reviews Taussig's position that specifies Western medicine as an ideological practice that reifies signs, experiences, and outcomes, as desocialized facts of nature in order to legitimize its practices and ceremonies.
In light of this, it is not surprising that Young comments,

...by denying the social relations embodied in sickness, these practitioners turn clinical medicine into a science of (apparently) real things, and transmogrify reality into a world of a priori objects beholden only to their own forces and laws dutifully illuminated for us by professional experts such as doctors (1982:275).

Ultimately, however, Young believes the task of the anthropology of sickness as not one to demystify knowledge, but to critically examine the social conditions of knowledge production. The anthropologists of illness, like Kleinman, he maintains, while inclined to recognize the importance of the larger socio-cultural context, generally postpone the task of its analysis. He maintains that “key concepts in the anthropology of illness ---i.e. healing, efficacy, explanatory models, and semantic illness networks--- cannot be understood merely in relation to one another” because they are related components in a socially determined system of knowledge production (1982:280).

However, “philosophical and theoretical reformulation of medical theory is necessary but not sufficient” (Good et al. 1982:192). The following article illustrates how it is possible for physicians to utilize new clinical models which place meaningful patterning of symptoms at the very heart of the clinical enterprise. Good et al (1982) depict clinical reasoning as based on knowledge of a causal chain at the biological level, as clinicians convert the patient’s complaints into labeled diseases and carry out rational treatment (1980:166). Recognizing the limitations of this treatment process they seek to introduce anthropological and sociological insights, i.e. a meaning centered approach, as a basis for restructuring clinical practice. In their paper “The Meaning of Symptoms: A Cultural Hermeneutic Model for Clinical Practice”, they outline a framework for this approach and
describe their experiences in teaching this model to physicians in a residency program where their objective is to teach understanding.

Symptoms are viewed as an expression of the sufferer’s reality and as linked to associated stresses and experiences that constitute the personal meaning of illness. The interpretive task is to understand the meaning of the symptoms and the illness for the sufferer (1980:180).

Residents are taught to utilize clinical techniques “to increase their ability to elicit and analyze the meaning illness has for a patient and to become conscious of their role as translators across medical subcultures” (1980:182). Essentially this approach represents a humanizing of patient care that is lost when clinical reasoning, in search of biological referents, supersedes the patient’s experience of suffering.

I have attempted to illustrate with these articles how medical anthropology has contributed to new ways of thinking about health and illness. Illness has been recognized as more than a causal relationship between symptoms and biology. It has been characterized as “a form of communication---the language of the organs---” (Lock et al. 1990:71); “as a coherent syndrome of meaning and experience that is linked to a societies deep semantic and value structure” (Good et al. 1980:175); and as part of the “process for socializing disease” (Young 1982:270). Reductionism has been rejected in favor of relativity. Even so, all of the authors I have cited above are clear in their acknowledgment of the efficacy and benefits of the biomedicine. Nonetheless there is a need to fill in the gaps of a paradigm that addresses only half the equation.

Physicians and other providers are not naturally motivated to ask questions and state problems from the patient’s point of view. They continually see things in terms of the way they were trained and the specialty they entered (Weed in Pfifferling 1980:197).
If we consider human beings as sentient bridges of biology and culture, then sickness becomes a treatable reality only as it enters the world of human meaning, and is expressed as a culturally constructed illness experience. Modern medicine, bedfellow of biology and impregnated with the Cartesian paradigm, reduces the illness experience to causal explanations of clinical phenomena. We have then, in cross-cultural health care, a conflicting set of realities involving not only the underlying dynamics of culture, but also diverse ways of defining the illness experience.
MATERIA MEDICA

There is no monolithic, external, objective set of facts to which we can appeal in determining what is medically real; our medical reality, including the therapies we deem to be valuable, is deeply affected by the meanings we glean, which are in turn guided by the metaphors we employ. ---Larry Dossey M.D.

In this chapter I intend to examine political, social and historical elements that have shaped the practice of biomedicine in the United States and its development as our “folk model” for disease. While a comprehensive analysis is beyond the scope of this thesis, the aspects I have chosen to focus upon will furnish an overview and form a basis for understanding the biomedical perspective as I present it here.

I begin Part I by examining science and the biomedical model and the body as machine metaphor, and conclude with a synopsis of the bounding of medical practice in America. Part II turns to an inspection of culture and Western medicine. My intent here is to demonstrate the connection between underlying socio-cultural beliefs and the practice of biomedicine in America.

The analytical perspective of biomedicine has been linked with the development of an empirical methodology in science (Good et al 1980; Gordon 1988). In the preceding chapter, I have examined how that paradigm has influenced the perspectives and conclusions drawn by contemporary medical researchers in their studies of international
students. The reductionist perspective, I argued, leaves untold the socio-cultural dimensions of the illness experience and provides an impetus for the use of qualitative methods as a means of addressing this gap.

Part I: FOUNDATIONS OF BIOMEDICINE

Science and the Biomedical Model

The beginnings of modern science lay in the scientific revolution of the seventeenth century; this was an era marked by change. The monopoly on learning and scholarly research held by the church for centuries was challenged by new ideas articulated by, among others, Descartes, Galileo, and Newton. Enlightenment intellectuals rejected metaphysical methodologies in their search for truth and broke with the church; creating a schism that ultimately led to the dualistic worldview that remains central to Western contemporary philosophy (Engle 1977; Capra 1982; Brown 1986; Kirmayer 1988).

Descartes' cogito, made mind more certain than matter, and led him to the conclusion the two were separate and fundamentally different. Thus he asserted "there is nothing included in the concept of the body that belongs to the mind; and nothing in that of the mind that belongs to the body" (Capra 1982:59).

The perceptual transformation that this thinking activated was revolutionary. A new vision of the world, and man's place in it, was born of the Age of Enlightenment. Jacob Bronowski has described the change in the following way:

We could say that the Middle Ages saw nature as a striving towards its own inner order; and that the Scientific Revolution overthrew this order and put in its place the mechanism of causes. ...what marks the scientific view is not that it turned to the mechanism of causes, but that it saw the world as a
mechanism at all ---a machine of events. The Scientific Revolution was a change from a world of things ordered to their ideal, to a world of events running in a steady mechanism of before and after (Bronowski 1978:25) (my emphasis).

This conception of the world is inherently linear. The events of life are now connected horizontally, carried along in the river of time, “as a river carries with it the boats and ships that float on its surface--they are not a part of it, and it is not a part of them” (Jones in Gordon 1988:29)

The magnitude of this change lies in realizing the new meaning it ascribed to the notion of truth. As events become connected more through the laws of nature rather than through individual lives, truth extends beyond time and the fluctuations of private lives. In light of this it follows that now the acquisition of knowledge is thought of as cumulative, which from a medical perspective, is frequently interpreted as an unfolding of truth about nature’s diseases (Gordon 1988). We have then one way of understanding the Western scientific paradigm; knowledge is acquired through the cumulative discovery of the laws of Nature.

While it may be the case that scientific researchers and philosophers are well versed in the dynamic qualities inherent in the search for knowledge, I would argue that some physicians “fear the absence of a sure, objective foundation for knowledge” (Lock et al. 1990). These physicians, faced with bridging the gap between a research finding and its human application may take a dogmatic view of scientific knowledge as they use it to validate their diagnoses and treatment procedures. They are, however, supported in this. First, by an underlying socio-cultural belief system that validates the reality of the naturalist paradigm and second, by political and legal maneuvering in the past and present that has tended to support the
practice of biomedicine in the United States to the exclusion of other medical practices.

Body As Machine

Healers traditionally addressed illness as an “interplay between the body and soul and had treated their patients within the context of their social and spiritual environment” (Capra 1983:126). The starkly biological approach to illness is attributable, in part, to the scientific notion of the body as a machine that can be analyzed in terms of its parts.

With mind-body dualism firmly established...classical science readily fostered the notion of the body as a machine, and of the doctor’s task as repair of the machine (Engle 1977:131)

Larry Dossey M.D. (1991) illustrates the difficulty overcoming this view,

I, and perhaps all modern physicians, have been trained to believe that...it is only the blind play of the atoms and molecules in the body that is important. It is “bad science” to suggest that the perceived meanings of patients can affect the body (1991:9).

This drive to avoid “bad science” however, has often left the practice of medicine devoid of humanity. Jacob Bronowski has stated, “The body of technical science burdens us because we are trying to use it without the spirit” (in Brown 1986:101). Critics of the analytical view maintain that, “in concentrating our attention on quantities rather than qualities...it [demonstrates] concern with things and not people, thus encouraging us to treat people as things, and thereby has impoverished our whole attitude to human relations...” (Brown 1986:104). As this view is manifested in medical practice we see physicians "...concentrating on smaller and smaller fragments of the body ... losing sight of the patient as a human being.”(Capra 1982:123). Furthermore, public dissatisfaction with a
starkly biological view of the human body increasingly appears in the alternative popular literature. Here, writers assert that in a time of increasingly technological and skilled medical practice we no longer consider physicians healers resulting in a doctor-patient relationship that is considered extraneous to the practice of medicine, thus stripping medical practice of the human dimension (Vegetarian Times 1993). Finally, Andrew Weil maintains that the technological dream that supported biomedicine has begun to fade as increasing numbers of patients begin to question the risks, increasing costs and efficacy. (Weil 1988).

Despite the increasing recognition of the limitations of biomedicine and calls for new models of treatment, biomedicine persists as the dominant medical system in the United States. Why? Part of the answer lies in the history of medical practice in America.

A Laconic Look at Materia Medica

The history of medical practice in America is exemplified by a long and complex struggle. The following discussion reveals only a small part of that struggle. It is important however, if we are to understand how biomedicine has become the dominant medical system in the United States.

The period from 1780 to 1850, known as the Age of Heroic medicine, attributed all illness symptoms to bad blood, and advocated bleeding as the recommended method of treatment, to be supplemented with induced vomiting, blistering, sweating, and intestinal purging induced with huge doses of calomel (mercurous chloride) (Weil 1988).

In America, Benjamin Rush, signer of the Declaration of Independence, and a heroic physician was a proponent of this doctrine. Rush was said to have persuaded his patients to allow treatment by
convincing them that they also were, "heroic, bold, courageous, manly, and patriotic (Payer 1988:128). An account of the death of George Washington reveals the lengths to which physicians were willing to go and perhaps why patients had to be persuaded to allow treatment:

On December 14, 1799, the former President came down with a severe sore throat. His overseer removed a pint of blood, but it provided no relief. A physician was called, who...applied a blister to the throat and let another pint of blood. Two other doctors came to consult, and by a vote of two to one, they decided to let more blood, removing a quart at that time. Washington died sometime between ten and eleven that same night. In this case heroic treatment consisted of the removal of at least four pints of blood, blistering and a dose of calomel (Kaufman in Weil 1988:14).

This type of treatment was in direct opposition to that advocated by Samuel Hahneman, a German physician who though trained in this procedure, rejected it and today is credited as the father of homeopathy (Weil 1988). In light of the number of patients sped to their death under the rigors of heroic medicine, Hahneman's gentler therapeutics found an avid following in America and in 1844 the, "American Institute of Homeopathy became the first national medical society" (Weil 1988:20).

However, allopathic---heroic physicians---had worked from as early as 1722 to secure their status.

...regular doctors in the American colonies began to organize and secure legislation favorable to themselves. Soon after independence they set up state medical societies and mechanisms for licensing physicians, always with the intent to exclude from practice "irregular"(sic) doctors who were not schooled and approved by the orthodox establishment (Weil 1988:20).

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1 Hahnemann coined the words allopathic and homeopathic. He called medicine practiced by his peers allopathic meaning 'other than disease' as he felt they prescribed drugs on the basis of no consistent or logical relationship to symptoms. He called his treatments homeopathic 'like the disease' because it was based on the idea that, like cures like.
The Popular Health Movement organized as a backlash to the political and legal maneuvering of elitist medical societies. However, while they managed to overturn some exclusionary legislation, the “allopaths organized, this time into a much more cohesive and effective political lobby; the American Medical Association, formed in 1846” (Weil 1988:22). The militant zeal of this organization was such that by the end of the nineteenth century they had effectively barred all non-allopathic physicians from the legal practice of medicine. In 1847 the American Medical Association adopted its code of ethics that stated: “No one can be considered a regular practitioner, or a fit associate in consultation, whose practice is based on an exclusive dogma, to the rejection of the accumulated experience of the profession” (Weil 1988:22) The term exclusive dogma was aimed at homeopathy, and served to isolate it as an unacceptable medical practice. This position was further defined by Oliver Wendell Holmes, then professor at Harvard Medical School, who published an attack on homeopathy titled “Homeopathy and Its Kindred Delusions” (Weil 1988:22). By the 1860’s, the American Medical Association was working to monopolize city hospitals and boards of health, threatening boycotts where ever they encountered homeopaths, whom they also managed to prevent from enlisting in the Army Medical Corp during the Civil War. In the 1870’s, the American Medical Association denied admittance to well-qualified women, delegates from racially integrated medical societies and refused admittance to the entire Massachusetts Medical Society unless they vanquished homeopaths. (Weil 1988) The unrelenting pressure of the American Medical Association eventually succeeded in getting all the “licensing laws back on the books, and homeopaths were systematically hounded out of positions of power and
importance" (Weil 1988:22). The political and legal bounding of medicine has continued up to the present.

...the Medical establishment is not primarily engaged in the disinterested pursuit of knowledge and the translation of that knowledge into medical practice; rather in significant part it is engaged in special interest advocacy, pursuing and preserving social power (Engle 1977:135).

These efforts were further bolstered by the 19th century triumphs of scientific medicine over infectious illness. Indeed throughout the first half of the 1900's, "any diseases not understood were thought to be intractable and capricious---that is, a disease not understood---in an era when medicine's central premise is that all diseases can be cured" (Sontag 1979:5).
Part II: ANTHROPOLOGY AND MEDICINE

To this point I have briefly outlined the connection between empirical thought and the biomedical model, and the background of medical practice in America in terms of its political and historical origins. However, I still have not fully answered why biomedicine has become, as Engle (1976) phrased it, our “folk model” for treatment of disease. In order to answer this we must turn to an examination of culture.

Perhaps due to the stunning achievements of medical science, practitioners of biomedicine assumed that their science was essentially and exclusively true. Thus, “for many years social scientists left unquestioned the dominant ideology of their time; scientific facts were reified, assumed to be pristine and beyond the realm of social analysis” (Lock 1988:3). However, anthropologists and medical critics have been struck by this reductionism which excludes alternatives and which asserts a biological universalism and individualism which ignore, if not deny, basic anthropological understandings which see cultural and social forces as wellsprings of human behavior, including healing and suffering (Gaines and Hahn 1985:3).

Eventually, the upsurge in criticism of reductionist science led to a growing interest in the study of cosmopolitan medicine and it came under study by a number researchers (Hahn & Gaines 1985; Lock & Gordon 1988; Good and Good 1980; Kleinman 1980; Gordon 1988; Kirmayer 1988). In the following section, I will draw on these earlier works for help in creating a framework from which the meanings and values implicit in biomedical practice can be illuminated.

Biomedicine in America: An Anthropological View

Two anthropologists who provide further insights are Deborah R. Gordon (1988) and Lawrence J. Kirmayer (1988). Their essays demonstrate
the cultural and social variables that function to support certain beliefs about biomedicine. My intention in presenting their work here is twofold. First, this literature succinctly establishes biomedicine as a cultural product of the West, and second by illuminating this cultural connection, we may gain an understanding of the ubiquitous acceptance of biomedicine despite its limitations. These premises provide a foundation for further insight into the perspectives of both patient and practitioner in the cross-cultural setting.

**Biomedicine and the Naturalist Paradigm**

Deborah R. Gordon acknowledges the prestige and dominance of the naturalist paradigm as clearly linked to the social, political, and personal investments in the current model. She questions, as W. T. Jones (1976) has before her, “how might the world-view of practitioners and patients affect a medical system by limiting its ability to change?” (1988:23). Her response to this question focuses on naturalism, biomedicine, and individualism, and the mutual supports between them. In essence she argues, biological advances have throughout the history of western science gone hand in hand with medicine. Given this, it follows that assumptions inherent in the naturalist, i.e. scientific paradigm, appear in biomedicine. Biomedicine, in turn, functions as an arena where these distinctions are played out publicly. Gordon reveals this connection by illustrating seven expressions of the naturalist paradigm in biomedical practice. I will summarize her examples here.

1. **Nature is Distinct from the Supernatural: Matter is Opposed to Spirit.**

   Health and illness are defined in terms of material indicators, such as blood pressure, rather than spirit such as feeling healthy.

Nature is a thing-in-itself — objective, indifferent to human purpose. Subjective meaning is exterior to the being of objects. Health or illness is defined more through objective data offered by the body than the experience of the patient.

3. Atomism: The Part is Independent of and Primordial to the Whole

Atomism of many sorts prevails in medicine: diseases are considered separate from their specific hosts — his/her body divided into parts and parts which are approached as autonomous units. Health and illness, life and death are seen as discrete and opposed entities not complementary parts of each other. Medicine has thrived on biological reductionism.

4. Nature is Separate from Culture

It assumes that underneath all the exterior cultural coating—specifically underneath anatomy at the levels of physiology and biochemistry—all humans are basically the same.

5. Nature is Separate from Morality

In naturalism it is assumed that nature is indifferent to the good and bad—to human values and morality in general. Instead of judging, medicine diagnoses, explains how and treats.

6. Nature is Autonomous from Society

What is natural is beyond the sphere of social influence. In medicine, disease is essentially an individual problem and is systematically abstracted from a social context.

7. Nature/Truth is Universal, Autonomous from Time or Space

The history of medicine is cumulative. Medicine is propelled by abstractions which are taken as real. Medicine’s prejudice for diagnosis, that is, placing an event in a class, reflects this bias. As a thing the body is neither a person nor something sacred (a thou) but run by mechanisms and best approached
objectively through the purest and most objective of languages—numbers (Gordon 1988:25-31).

According to Gordon then, it is our acceptance of the naturalist paradigm as representative of truth, that supports and sustains the practice of biomedicine, as these same tenets are recreated within the domains of the biomedical model. Furthermore, this philosophy of natural science legitimizes the objectifying of patients which permits physicians to view humans outside of society and illness as free of human meaning, even as it leaves unaddressed the patient’s reality of illness, that is, the non-biological meaning of illness.

Finally, the legal language of equal rights and justice supports the individual and sustains the Western notion of freedom; that is, “The ability to act on one’s own, without outside interference or subordination to outside authority” (Taylor in Gordon 1988:34). Between individuals then, ideal relationships rise out of consent and contract “a model that is quickly growing in medicine” (Gordon 1988:34).

In fact, biomedicine is now a central stage in which the assertion of autonomy takes place. Rights are claimed for everyone and everything, from fetuses to wombs, to neonatals, to people in comas. Contracts between “informed partners” are becoming the means for increasing the “equality” of patients vis-à-vis physicians (Gordon 1988:41).

Biomedicine and Scientific Rationality

A final article I would like to address here is that of Laurence Kirmayer (1988). My intent is to further elucidate the underlying assumptions obscured by biomedical claims of neutrality and rationality.

Laurence Kirmayer uses the body-machine metaphor to examine the biomedical claim of scientific rationality. This view presumes “The
patient is the owner of the body-machine which is brought to the physician for repairs" (1988:57).

Kirmayer maintains that patients who deviate from expected behaviors associated with the sick role may be blamed for their illness or judged irrational. In addition he suggests that unexplained failures of treatment are blamed on the patient even when total compliance has been maintained. "...these maneuvers act to maintain the rationality and coherence of the biomedical world view even when they disqualify the patient's suffering or moral agency" (1988:58).

Furthermore, according to Kirmayer, the emergence of holistic approaches to healing, though corrective, ultimately result in invoking the same values of rational control that are part of the biomedical approach.

In the healing vision of psychosomatic medicine, mind and body are to be brought into harmony. Most often however, this goal is described not as an equal marriage but as the re-establishment of the mind's dominance and control over the body and with it reason over emotion ...ultimately invoking the same values of rational control and distance from passion and bodily-felt meaning that are a part of the mechanistic world view of biomedicine (1988:58).

Kirmayer attributes this failure not to the intent of the holistic practitioner as such, but as validation of the deeply entrenched concept of dualism held in Western experience. "This does not originate in the ideology or practice of medicine but, in both its biological and psychological approaches to irrationality and sickness" (1988:58). Kirmayer unequivocally connects the fundamental position of mind-body dualism in Western culture with the "moral problem of sickness" (1988:82). Problems unexplained by biology pose a threat to the rational order and authority of biomedicine; and patients become "either rational but morally suspect in
choosing to be sick or irrational and thus morally blameless but mentally incompetent” (1988:83).

Moreover, as mentioned above, Kirmayer asserts that attempts at holistic medicine fail, as they ultimately reproduce the same Cartesian split. In order to transcend the limitations of biomedicine, he states, we must move toward an active concern and care for the patient.

Caring begins with accepting the phenomenal reality of the patient’s suffering, including its moral significance to the patient and others. But biological, psychological, and social attributions of cause and responsibility must be seen as therapeutic measures that express values rather than as morally neutral (Kirmayer 1988:82).

In this chapter, I have examined facets of historical, political, social and cultural variables that together support and sustain the practice of biomedicine in America. As we come to more fully understand the background of American medicine we deepen our understanding of the nature of the cross-cultural medical experience. As Jones has commented,

Explanation consists in tracing the historical development that has brought it about that, E, is what it is now. When we have learned E’s history in detail, we know everything about E that there is to know (Jones 1976: 389).
CHAPTER FOUR

METHODOLOGIES: BLUEPRINTS FOR DISCOVERY

Getting started can be very hard for people who have trouble with beginnings. After all where do beginnings, begin?

---Dorthy Bryant

Michael Agar comments,

In ethnography, you learn something ("collect some data"), then you try to make sense out of it ("analysis"), then you go back and see if the interpretation makes sense in light of new experience ("collect more data"), then you refine your interpretation ("more analysis"), and so on. The process is dialectic, not linear (1980:9).

This thesis is a platform for the presentation of what I have learned from a particular group of Asian students about their concerns regarding issues of health care, ("collected some data") and the interpretation presented later demonstrates how I have made sense of it ("analysis"). As Agar implies, this sort of research is heuristic in nature. The sum of this thesis represents a beginning not an end, as I have traveled only a short distance down the road of discovery. In the following chapter I describe my perspective as it is reflected in my choice of research methods and ultimately in what I consider to be useful information.

Scientific inquiry often begins with the question, "How can we discover true and useful information about a particular domain of
phenomena in our universe?" (Pelto & Pelto 1970:1). However, what we consider to be true and useful information is often a matter of perspective. In the previous chapter I illustrated, through the writings of various authors, the different ways people think about issues of health and illness. Clearly, perspective, reflects one's beliefs about what is real. Scientific methodology grounded in empiricism bounds reality with explanation and prediction of phenomena through observation, theory, and mathematical analysis. The predominance of this tradition has led most physician researchers to adhere to quantifiable research designs, with the consequent focus on surveys, statistics, anomalies, and syndromes, in place of naturalistic studies.

Empirical methodologies "require the scientist to adopt a mediate, or external, attitude toward the objects he studies" (Jones 1976:390). We see ample evidence of these influences in the social sciences. Indeed didactic readings from Comte to contemporary anthropologists hold the "idea of a mechanistic science of humanity as plausible as the idea of a mechanistic science of other natural phenomena" (Barnard 1988:18). Certainly instructive literature on anthropological research such as Pelto & Pelto (1970) devote their preliminary chapters to defining and expanding the meaning of "doing science" enough to neatly shoehorn social research into a more traditional definition of scientific inquiry. Nevertheless, it would seem, that to measure truth and value solely by the yardstick of scientific method is ultimately limiting and probably deceptive since, "tacit assumptions about the world find their way into the theories of every academic discipline..." (Spradley 1979:11).

I find that too often doing science as described above overlooks people, their experiences, personal stories, and the larger socio-cultural
environment. There are those who advocate the use of alternative methodologies, particularly as agency and other personnel recognize naturalistic studies as helpful in achieving a better understanding of themselves and those they serve (Agar 1980; Spradley 1979; Wolcott 1990). Perhaps it is through the utilization of both qualitative and quantitative research methods that we have the best opportunity for finding true and useful information about a particular phenomena. As Agar has stated, “Without science, we lose our credibility. Without humanity, we lose our ability to understand others” (1980:13).

I do not remove myself from Jones (1976) assertion that preference for a particular methodology is revealing of world view. As Geertz has commented “...that what we call our data are really our own constructions of other people’s constructions of what they and their compatriots are up to...” (1973:9). Thus as I hope my title implies, any attempt to interpret reality, is at best an elusive quest. It is like trying to catch a single snowflake; after a while you realize there's no such thing as a single snowflake. A single snowflake is something you can imagine, something you can visualize, but you'll never hold one in your hand. As I offer up my “interpretations of a snowflake” please recall, I’ve never held one in my hand, all I can tell you is how I have imagined it to be and invite others to imagine their own. It is through the sharing of diverse ideas and dialogue that we enrich ourselves and stimulate awareness.

My perspectives and preferences have inevitably shaped the direction of this thesis. My choice of qualitative methodology stems from my perspective that quantitative methodologies are ineffective if the information being sought is a derivative of the process of culture rather than the product of culture.
People do not speak explicitly about the effects of culture in their lives, in fact most people remain unaware of culture as an influence in their lives. As Edward Hall has commented, culture is a hidden dimension that lies unseen and outside of voluntary control. Clearly, any attempt to quantify something that people cannot or have not conceptualized themselves is a tenuous proposition.

Furthermore, in contrast to those researchers reviewed in Chapter two, my interest lies in understanding the student's perceptions of the events and experiences they have regarding health care. The stories they shared with me about those experiences are what I consider useful information, to attempt to bound that information in order to apply standardized testing diminishes the whole experience. Michael Agar elaborates on differences in research methodologies stating,

...another difference between hypothesis-testers and ethnographers---has to do with a fundamental difference in research world view. An ethnographer learns something new, and then tries to understand how it connects with other aspects of the situation ... then tries to see if it connects with other things he has learned that are not immediately apparent (1980:75).

This perspective acknowledges the dynamic and processual qualities of human experience which cannot be understood in isolation from one another and, with regard to this inquiry, are influential in my perspective. This view leads me to transcend the narrow biological view of health and illness to search for the meaning within the larger context of culture. As Krober has stated “...on the uppermost [levels] of culture, it is the qualitative and the contextual associations of phenomena that are important...” (1952:5)

Jones illustrates this view in his description of Renee Fox:
... she is not merely interested in describing the relation that holds between joking and the reduction of anxiety; she sympathizes with the physicians, wants us to share her sympathy, and writes in a way that is calculated to help us do so. She wants us to feel what it feels like ... (1976:391).

In much this same way I wanted to know what it was like for international students in school at Oregon State University when they became ill. How did they cope when they got sick? What did they do? How did their experiences here compare with their experiences at home?

In seeking answers to these questions I have begun the first part of a multifaceted process, reserving for another day the "collection of more data" and "more analysis".

COLLECTING SOME DATA

Meeting OSU Research Requirements

Before any students were contacted, a research design and summary were submitted to the Oregon State University Human Subjects Committee. They approved the research and all regulations required by the committee were adhered to during the course of the research. There was no financial sponsorship of this research; it was undertaken as partial fulfillment of the requirements for the M.A.I.S. degree in Anthropology at Oregon State University.

Participants

I conducted sixteen individual and three focus group interviews over the course of the 1991-1992 school year. In all I interviewed twenty-eight people, eight Chinese students, eight Japanese students, seven Korean students, and five health care providers.
The Students

The students were comprised of twelve women and eleven men. Eighteen were graduate students. A majority of the students lived in off campus housing. Most students had lived in the United States for two years, ranging from a low of four months to a high of five years. Eleven students were married.

The Health Care Providers

I received permission from the director of the Student Health Center to interview physicians and other providers at the clinic. I interviewed two men and three women at the clinic, in their offices. All of the clinicians were Caucasian. My first two interviews were with individuals I knew at the clinic, and after this I contacted other providers on the basis of referrals solicited at the conclusion of the interviews.

General Guidelines for the Interviews

All of the interviews, individual and focus group, began with my promise of confidentiality and anonymity. In addition I made sure everyone had a written copy of my name and phone number, and the names and campus phone numbers of faculty on my committee. I encouraged people to contact me or the committee faculty if they had any questions or concerns that arose later. I also informed people that they were free to respond as they felt appropriate, that no one was compelled to answer any question they did not want to, and that they could withdraw from the interviews at anytime without penalty. Finally, I offered myself as a resource, inviting people to contact me if they needed help with any problems that might arise from schoolwork or their daily lives.
Most frequently my first contact with students was by phone and if they agreed to be interviewed we arranged a mutually convenient time to meet. I generally conducted the interviews in private, assuming people would be more relaxed if they did not have to worry about others listening to their responses. Also, since I usually audio-taped the interviews, I was able to make recordings free of background interference.

In explaining the research, I told them I was a graduate student in anthropology and that this project was the basis for my thesis; and although my focus was on health care, I was also interested in all of their experiences while living in Corvallis and going to school at Oregon State. While this seems straightforward enough, it was one of the first issues I struggled with in conducting the interviews. I was sensitive to some student's sense of being different and wanting to fit in, and I didn't want my inquiries to further define for them the differences they were already aware of. Thus it was always a bit of a struggle to explain my research in a way that communicated my desire to learn about them as individuals and to understand how they were affected by the experiences they chose to share with me, without making it appear I was stereotyping them as part of a group.

The Individual Interviews

These interviews began in October 1991. In all I interviewed sixteen people: four Chinese students, five Japanese students, two Korean students, and five health care providers from the OSU student health center. Each person was interviewed one time. The first students I contacted for interviews were selected as a result of suggestions I solicited from faculty in my department. They recommended students they knew
and thought were likely to participate in the research. As the term snowball sample implies, other students were contacted as referrals from the initial interviews.

I generally met with students in places they suggested, most often this was on campus in the library or cafeteria. However, if they didn’t have a particular place, I arranged for us to meet in a classroom made available to me by my department.

Agar (1980) defined the informal interview as, “informal for a variety of reasons. First you don’t have a written list of questions. The ethnographer is very much in the one-down position. He doesn’t know enough to ask the appropriate specific questions this early in the dance” (1980:90). In keeping with this idea, I arrived at the interviews with only a few general open-ended questions in mind to help initiate a dialogue. For example: What’s it been like for you living here?, or How did you decide to come to Oregon State? I would then follow their leads as I wanted them to direct the dialogue. Although they were aware of my interest in their health care experiences, sometimes we would spend the majority of the interview talking about subjects other than health, but I felt that if people thought something was important enough to share it with me without my prodding for information, then I would listen. My genuine interest in these extra stories contributed to our rapport. Sometimes students shared personal experiences and in discussing these a bond of trust developed between us and I always appreciated the opportunity to get to know people better.

Agar comments, “In the informal interview, everything is negotiable” (1980:90). I take this to mean, that the format of the informal interview is flexible, that is, informant-directed. This was the view I took
during the course of my interviews, especially when students veered off the
topic. Learning often occurs when it is least expected. However, when I
could gracefully manage it, I would try to steer the conversation toward
health care. I generally tried to paraphrase their responses for
clarification or as a tactic to elicit further responses. Sometimes the
conversations flowed and other times they didn't. For example, students
were sometimes puzzled about the informal style of the interviews,
especially those with a strong scientific background. They expected the
interview to be very directed so they would often answer in short phrases or
with simply yes or no, leaving me scrambling to keep the conversation
going. I also became aware of my own social conditioning as I sometimes
jumped too quickly to fill in the silence, when people paused before
finishing their statements. The interviews with the health care providers
followed the same open-ended format as the student interviews and were
conducted during this same time period. I generally opened the discussion
by asking, "How would you describe your experiences treating
international students to other clinicians who have not had this
experience?" In these interviews once the conversation began my input was
minimal to keep the discussion going. Again I used paraphrasing to
clarify and expand on information and ideas they provided.

The individual interviews lasted anywhere from fifty minutes to over
one hour and were completed by December of 1991. I interviewed each
informant only one time.

The Focus Group Interviews

In January of 1992 I began doing focus group interviewing. I
intended to have a minimum of five in each group and always invited at
least five students to attend. However, since I could not require people to come and had little but a cup of tea and a cookie to offer them I was generally happy when anyone showed up! In all I had three separate groups composed of: four Chinese students, three Japanese students, and five Korean students. These interviews usually lasted from one to two hours, and again I met with them only one time. The individuals who participated in these interviews were referrals from students I had previously interviewed as individuals, or contacted through international student organizations on campus when it was too difficult for students to refer me to the number of people I requested or if individuals contacted declined to participate.

I decided to try this format to see if people might speak more freely among friends, or at least other students from their native country. I wanted to generate discussions among people, and as much as possible, take myself out of the dialogue in an attempt to produce a more natural discourse. I hoped to discover new issues and concerns or review topics that had been discussed in the individual interviews.

Basch (1987) has defined focus groups as:

A qualitative research technique used to obtain data about feelings and opinions of small groups of participants about a given problem, experience, service or other phenomenon (1987:414).

Lofland & Lofland (1984) stated that group interviewing,

...has the advantage of allowing people more time to reflect and to recall experiences; also something that one person mentions can spur memories and opinions in others. Finally, people may not agree with one another on matters of opinion, providing instances of interchange between contrasting perspectives (1984:15).
As with the previous set of interviews I continued to record them on audio tape. I generally arranged for the groups to meet on campus in the classroom my department had made available to me. It was private, quiet and convenient since we usually met at the lunch hour or after classes in the late afternoon. I placed chairs around a large table so that everyone was close together and could see each other. I always sat in between people and never at the head of the table in the hope that people would see me as part of the group and not the leader. I provided tea and cookies to try to make it as pleasurable as I could for people.

I generally started off the conversations with the same question I used in the individual interviews. For example, What has it been like for you to live in the United States? As soon as it seemed everyone had exhausted this topic, I asked another open-ended question, only this time I directed it toward health. For example, How has your health been since you’ve been here, or What do you do when you get sick? These generally were enough to get the dialogue started. As with the individual interviews I listened and interjected only when it seemed everyone was finished talking. Then I would either ask another question or paraphrase something someone had said to clarify or generate more discussion. I did have a list of questions I used as a guideline. (see Appendix A) These helped me keep the discussion on track and addressed some of the same topics that had emerged from the individual interviews which I wanted to review in search of new issues, concerns or topics.

Everyone was told ahead of time the interviews would be taped. However, the tape recorder seemed a source of tension, at least initially before people got involved in the conversations. They were pretty quiet,
looking down, or doodling. It reminded me of the nervous anticipation you see in a new class on the first day. I would try to counteract this tension by holding it while I put in a tape and then nonchalantly turning it on as I explained the project and gave them the preliminary information about what we were going to be doing. This seemed to be enough to allay most people’s tension, and once the conversations got going I think the majority forgot it was even on.

I structured these interviews around many of the suggestions laid out by Basch (1987) especially those pertaining to the role of the moderator, the physical setting and psychological climate, using a tape-recorder, and communicating goals to the participants.

Another reason I opted for the focus group technique was my concern that people may have held back comments they might ordinarily have talked about with friends. It was natural for them to not want to offend me, and I intended as the following statement suggests, that they would feel freer to disclose attitudes that might not have been in the individual interviews.

The group situation may also encourage participants to disclose behavior and attitudes that they might not consciously reveal in an individual interview situation. This occurs because participants often feel more comfortable and secure in the company of people who share similar opinions, attitudes and in the behavior (Folch-Lyon et al in Basch 1987:434).

I enjoyed the personal connection that is inherently a part of interviewing, and felt this interaction contributed to keener insights in my interpretation of their experiences. With regard to the focus groups, I found that the discussion between people was often lively, as differences in opinion and experience were debated, also participants were less reliant on
me to keep the dialogue going. I feel this was an excellent way to gain insight into the students perspectives, feelings and experiences.

LIMITATIONS OF THE RESEARCH

While I found informal interviewing useful and enjoyable I must reiterate this information does not allow for generalizing. The overall sample was small, and in focus group interviewing some participants will dominate over others, thus not all students are well represented. Furthermore, although informal interviews generally serve as a foundation for further research, follow-up interviews were not conducted. As pointed out at the beginning of this chapter, data collection and analysis is followed up with some more data collection and interpretation (Agar 1980). Thus this work represents only a beginning of the process. The ideas and topics rather than denoting an end, serve as springboards for further investigation. Furthermore, as I have pointed out earlier, any interpretive effort is itself the product of a particular perspective.

Additionally, I lack the intimate understanding of these cultural groups that comes from having lived in their countries. My information is a product of previous course work, and my associations with Asian international students as a peer, teaching assistant, and friend. This is particularly the case for students from Japan and China.

Thus, I recognize that this thesis reflects an interpretation of how things seem to me which may or may not be shared by others. However, I do maintain that this approach and my views offer new perspectives on cross-cultural medical encounters that previously have been ignored. Therefore this work fills a gap in the literature as it suggests new ways of thinking about old problems.
In the following chapters I will discuss what I have learned, and how I have tried to make sense out of it. As ethnography, this research represents a beginning with ample room for more data collection and analysis. As a method of inquiry it presupposes "the existence of alternative realities" (Spradley 1979:11). As a thesis it represents the culmination of a personal and intellectual experience that has enriched my understanding of culture.
CHAPTER FIVE

ENCOUNTERS

When we walk our way and encounter a man who comes toward us, walking his way, we know our way only and not his; for his comes to life for us only in the encounter

-----Martin Buber (Streep 1992:48)

The students who were interviewed for this thesis project all have had previous experience with biomedicine in their native countries and were familiar with this method of treatment. Thus, problems that arise in the cross-cultural medical situation cannot be attributed to the students unfamiliarity with this approach to medical care. Rather, if unfamiliarity is a factor it is based in the lack of shared meanings regarding the illness experience, that is, the effects of envisioning different realities. As Geertz has commented, “What prevents us from grasping what people are up to is not ignorance [but] a lack of familiarity with the imaginative universe within which their acts are signs” (1973:13).

As I have argued earlier, the cultural reality of international students is often overlooked by physicians and medical researchers who use quantitative and analytical methodologies to pursue answers to their questions. This is to say, they understand the individuals and problems they study with a uniquely Western scientific and biomedical perspective.

By contrast, in undertaking this thesis project I was not so concerned with testing a hypothesis, as exploring a perspective. My intent was simply
to discover the meaning of health care on an American campus through the eyes of those whose perspectives were not my own. In light of this I conducted the interviews in a manner I hoped would foster student engagement. I intended to allow the students to lead our conversations into areas of their concern. In the following pages I present the results of my discoveries.

I have divided the information into three general categories. (1). I begin with a category of relationships. Here, I illustrate the connection between cultural norms and expectations regarding the doctor-patient relationship using frameworks I have labeled the American co-participatory and Asian situation-centered. (2). This is followed with a look at health care providers and their perspectives regarding international students. I focus this discussion around two issues. The first examines the somatization of illness and the second the postponement of treatment by students. Both of these issues are addressed in the literature and by the providers I interviewed. My purpose here is to reveal the different perspectives held by students and providers regarding the circumstance of these issues.

(3). The final section deals with some of the more obvious practical dilemmas facing international students in their lives overseas. I demonstrate here that the problems and concerns voiced by the students interviewed for this project closely follow those reported in the studies reviewed in chapter two. I address these concerns separately as I do not concur with conclusions reached by others; namely, that these issues are reflective of syndromes or other psycho-social disorders they have been attributed to. Rather it is my position they simply represent one aspect of
the many challenges facing international students living overseas and thus deserve attention here.

A FRAMEWORK OF RELATIONSHIPS

The following discussion lays out a basic framework for understanding the conflicting perspectives of health care providers and Asian international students in the university health care setting. I will examine the student's comments and experiences as interpreted through this framework and in doing so illustrate the relevance of culture to the clinical setting.

The Co-Participatory Relationship

Often medical research focusing on culture examines certain behaviors or events rather than looking below the surface of these actions to the underlying values and beliefs motivating them (e.g. Sanford 1987; Huang 1977; Alexander and Shaw 1991). However, clinical settings mirror the socio-cultural environments they are a part of. Here, as in society, individuals are united by commonly held, culturally acquired, knowledge that sustains and supports particular ways of interacting with one another and the world around them.

With regard to the American physician-patient relationship I have labeled this way of interacting as co-participatory. This relationship rises from the "... western dedication to defending the sovereignty of the individual and ... ensuring equal treatment... as is expressed through the language of rights and justice (Gordon 1988:38). For Americans every person, in principle, is symbolic of humanity at large and as such is equal to every other person (Gordon 1988). The principle of equality and a direct, open style of communication, is embodied in the interactive dialogue
between physician and patient that American doctors rely on as a part of their diagnostic process. This discourse mirrors American core values as recounted in Chapter one of this thesis. It also reinforces a measure of autonomy between doctor and patient, thus affirming the ideal social relationship which rises "out of consent and contract between autonomous individuals" (Shweder and Bourne in Gordon 1988:38). This low context, non-hierarchical relationship stands in pointed contrast to the situation-centered orientation of Asian international students.

The Situation-Centered Relationship

Francis Hsu has described the situation-centered orientation as one that places an emphasis on the individual's appropriate place and behavior among his compatriots (1975). This view, as I suggested earlier, tends toward a valuing of relationships based on mutual dependency and responsibility, and is most clearly illustrated in the tenets of Confucianism, where family relationships provide a model for society. These notions of relationship are recreated in a high-context, hierarchical Asian medical setting. Here, physicians acquire the role and status of patriarch with its incumbent authority over, and responsibility for, the patient who presumes and depends upon a benevolent physician to know what is best and take care of him. These ways of interacting resonant with underlying cultural values.

PART I: STUDENT VIEWS OF MEDICAL ENCOUNTERS

I begin here with statements made by students that illustrate their beliefs regarding the doctor-patient relationship. These statements are
generally illustrative of the differences they perceive between their experiences with clinicians here and their experiences at home. For example,

Doctors here are more conservative, they have a wait and see attitude. Doctors in China are more definite and give treatment right away. (Chinese male)

Nurses in China mainly sort the patients, here you see the nurse first, she checks you over and does a lot. While I was waiting I joked with my friend that the doctor was in his office looking things up. (Chinese male)

Well, I think in Japanese society there is one unwritten thing going on; if you don't know, you don't talk. A lot of people think doctors know a lot and so maybe you don't have to know what's going on with you, you just trust your doctor. They'll just give you some medicine and they'll take care of it. (Japanese male)

These statements reflect a certain perception of status as it relates to the expected behaviors associated with particular roles. High status is a common correlate of the medical profession in many Asian cultures. The Chinese doctor's personal involvement in examining and treating patients explicitly illustrates his knowledge which serves to affirm his status and position within the context of the doctor-patient relationship. Furthermore, as Kleinman has suggested, in his studies of Taiwanese medicine, this relationship embodies the Confucian father-son, teacher-student paradigm and as such is rigidly authoritarian (1978).

This contrasts with the American model where status is revealed less through the doctor-patient relationship than it is through the physician's position within the hierarchy of the clinic. In the American clinic a doctor's status is attested to by the fact that he does not have to perform the tasks of obtaining medical histories and recording basic bodily functions. Instead his role is that of analyst and, upon deciding what
diagnostic tests and course of treatments he wants, he, like the corporate executive, delegates the performance of these tasks to others.

In both cases the possession of knowledge confers status and power but the different ways they are manifested in behaviors reflects a deeply different cultural orientation.

As a consequence some students may find it disconcerting to receive diagnosis and treatment from a nurse who they do not perceive to be in a position to do so.

When I went, I didn’t even see a doctor I saw the nurse and got a prescription that cost me forty dollars! (Chinese male)

Quite recently one of my friend’s wives got a TB test. She got a medium result from it, not even positive, just kind of in between. But she told me that the nurse looked at it not a doctor and the nurse said, ‘You have to take this medicine for six months’. Well, she took that medicine because she has such a language problem. But after she got home her husband straightened things out. But the nurse (his emphasis) had made the decision, even though the result was not clear! But for six months! And that medicine is very poisonous, you’ve got to be very careful. (Korean male)

The real knowledge of the nurse and her ability to carry out treatments is not the central issue here, rather it is the students perceptions of the role-relationships that are of concern.

Nurses in China mainly sort the patients. (Chinese male)

Nurses here take your temperature and blood pressure, in China the Doctor does that, but they wouldn’t do that for example if you came in with a hurt foot. (Chinese male)

Specifically, these statements reflect the situation-centered orientation of Asian students. They expect the physician to have authority over, and responsibility for, not only the patient, but his subordinates as
well. From this perspective then, the actions of American medical assistants, may upset the expected ordering of relationships.

The principles of relationality and hierarchy resurface when students describe their experiences with doctors at home. Consider the following. I have underlined key phrases for emphasis.

Doctors in China don’t have money as an incentive but it’s their responsibility to treat you. You don’t expect them to get friendly with you just to treat you. (Chinese male)

In Japan I wouldn’t expect doctors to be funny or have a sense of humor. Because of their authority the doctor is in a higher status, above you. (Japanese female)

In Japan you’re supposed to be quiet. The doctor has power and you can’t ask him questions, or if you do even if you don’t like the answer you have to obey him and show respect by following what they say. (Japanese female)

You just trust your doctor, they’ll just give you some medicine and they’ll take care of it. (Japanese male)

I don’t know exactly what they prescribe for me I know it’s antibiotics but I don’t know which kind. It kind of has no meaning to me. I don’t know about it so much for my sick problem, not so much in detail so I depend on them completely about that. (Japanese female)

There can be no doubt that Asian students bring with them a cultural paradigm that involves a different view of the roles and expected behaviors contained within the doctor-patient relationship.

Additionally, this perspective leads international students to see the issue of physician responsibility and incentive as taking a distinctly commercial twist in the United States.

I think American doctors are good but too expensive. They are responsible, mainly the way they treat you, they give good advise. They are also business people and are diplomatic. A doctor’s reputation is important because he gets patients by word of mouth. (Chinese female)
In China you don’t expect good service like you do here. If you complain too much you probably won’t see your nurse again she has so many patients it’s easy to avoid you. Here my grandmother was in the hospital. She’s very old and demanding, the nurses were very good and patient with her. Here hospitals tend to be a money making venture. (Chinese male)

Here it’s very expensive to go to the doctor and the doctor’s reputation is important. Because of this he has to do a good job. (Chinese female)

Doctors in China don’t have money as an incentive but it’s their responsibility to treat you. (Chinese male)

The commercial aspect of medical practice in America, from the students perspective, shifts the notion of health care from service to commodity. This has different meanings to different students. It may suggest to some students that they are valued more as a client than a patient. However, some students realized that, in some cases, this approach to medical care may mean better care and service than they might have received at home.

Doctors here are fun. They joke around with you. They are more patient too. (Chinese male)

In China everybody can go to the hospital and get everything for free so it’s always full and lacking funds, here you pay. (Chinese male)

In Korea, the medical system is terrible. There are too many patients and too few doctors. They don’t explain why they just do anything. They spend no time, here they give good explanations. (Korean male)

The service in China is not as good as here. There are long lines, you have a card and you have to wait to see the doctor. Everyone is together in a long hall and you can see each other. Once you see the doctor he writes the prescription there and you get the medicine in the hospital, it’s very cheap. Doctors in China are not as patient as here, they have so many patients. (Chinese male)
In a few cases their perception of the close relationship between money and medicine in the United States led students to question campus clinicians.

Sometimes they just have that reputation that they cannot do anything to help, or that can I trust them. But as long as I talk with them I didn't have any problem with them. I just wonder can I really trust them? (Japanese female)

Where are the doctors from, I mean why would they want to work for the small little fees and stuff here? (Chinese male)

Are the doctors in the health center real medical doctors? (Japanese female)

Many students expressed positive feelings about their experiences, and appreciated the openness of the co-participatory doctor-patient relationship. This seemed particularly so with regard to having things explained.

They do a good job explaining things to you, and nurses they do a good job. (Korean female)

The doctors and nurses here are very friendly, ...in the hospital the first time I met the doctor he told me his first name. It wouldn't happen in Japan. (Japanese female)

I was not so afraid of going there, and actually doctor and people who work over there are very nice, so I didn't have a problem to talk with them. (Japanese female)

Sometimes the doctor is very patient and asks do you feel like this or this and give some examples, and I say yeah, yeah exactly. (Japanese female)

Chinese doctors don't really tell you everything they just do it, they don't tell you what they are doing. (Chinese male)
The following dialogue is from the Japanese focus group interview:

Interviewer: *How important is it to have good communication with the doctor?*

Student 1: Like here, this woman would say now I'm going to do this. Now I'm putting this in. (female)

Student 2: Uh-huh, yeah. They say you may feel some pain. (female)

Student 1: Yeah, they use those words and it's really nice. (female)

Student 3: Yeah I think so too, you know what your going through. (female)

Student 2: They will tell you what you probably will feel, that's really important. (female)

The following dialogue is from a Chinese focus group interview:

Interviewer: *So how does communication between a Doctor and patient influence you?*

Student 1: It helps you so that you do not get so scared, when you go to see the doctor (yeah) and also you will not get so scared of an operation because by the way that he talks to you you slowly build up trust in the doctor. (female)

Interviewer: *So the communication between the patient and doctor increases how much you trust him?*

Student 2: Yeah. (female)

Interviewer: *And does it influence you whether you go back or not?*

Student 2: Yeah, oh of course it will. (male)

Student 3: Yeah, the doctors are so nice and so patient and sometimes go too slow. (male)

Individual interviews:

Female Japanese students who had utilized the women's health clinic expressed a sincere appreciation of the open, and comfortable atmosphere created for patients by the nurse practitioners there.

One time I went to the health center on the second floor, gynecology, because I cannot be pregnant in this country if I have boyfriend. That's why I went to there, and she explained
everything about the examination, and gave me a prescription for the pharmacy. It's kind of interesting experience because in Japan, I don't know, it's kind of hard for female to go to this kind of place because people might feel embarrassed or something like that. But now I talked with my mother about pill, I told her it's very nice that I can go for this kind of examination, because I'm 28 years old and I should get the exam every single year. She examined for breast cancer and everything, so it's kind of good system, because in Japan we don't have this kind of system at all. (Japanese female)

Seeing the doctor in Japan is very different. They want you to be quiet, and it seems like it's more secretive. Here they try to relax you, they play music, answer your questions, and try to make you more comfortable. (Japanese female)

Part II: CONTRASTING PERSPECTIVES

In the context of a co-participatory doctor-patient relationship the openness of the dialogue supports a level of equality between doctor and patient, the effect of which is twofold. First, patients are more likely to be involved in the process of diagnosing and treating their illness. Second, they are also more likely to be held responsible for failures when physicians are unable to affect change or if patients deviate in any way from the expected behaviors physicians associate with the sick role.

The threat that unexplained or uncontrolled sickness presents to the authority of biomedicine is neutralized by making the patient accountable for the illness (Kirmayer 1988:83). In this way the physician maintains the power in the relationship and any perceived equality held by the patient may be undermined, if they move beyond the bounds of the culturally constructed clinical reality. This becomes an issue for international students when they present with symptoms that cannot be linked to biological referents, that is when students somatize illness.
The following story recounted by a health care provider during an interview, concerns a student from Southeast Asia and illustrates the consequences of a sick role defined exclusively in accord with a clinical, rather than patient, reality.

I saw a young woman, who I believe, was from Vietnam and she hadn’t been in the country very long, but she did speak English very well. There was no problem of her understanding me or of my understanding her.

The bicycle accident was not a terribly severe one. She was more shaken up than she was hurt physically. Basically she didn't have any broken bones, no serious head injuries. I think maybe she had one small laceration that required a few sutures and so on. But the real problem, to me, over the next weeks, and I was able to convince her to come back to see me, was that she began to show signs that I thought were due to post traumatic stress syndrome. In fact she was able to relate finally, that some of her nightmares about the bike accident recalled some of her experiences as a child in Vietnam with the war problems, and I tried, I very much wanted her to see one of the psychologists or one of the psychiatrists and she absolutely would not do it.

I think that there is, and I know I've encountered this with some others pretty much dealing with that same thing, they really are not very accepting, certainly not as much as our American students are, of seeking counseling or psychiatric help. It's very difficult for them to understand that if there’s a problem that would be helpful to them. My young women who had the bicycle accident was willing to take a mild tranquilizer to sleep because she was literally not sleeping at all and of course the more she didn’t sleep the more anxious and distraught she was. When I last saw her about 6 months after the accident she still was having some problems with sleeping, not major, but she had not been back on a bicycle. And I, you know, my sense was that, in a sense, I had failed her and I felt bad about that. I would like to see them work through these things so that they can get on with a normal life. I guess that's my biggest concern about them. (female clinician)

Certainly the clinician is concerned about the welfare of the student. However, the willingness to accept that she had “failed” a patient rather than adjust a clinical perspective graphically illustrates the considerable impact of the biomedical model on health professionals in the United States. That is, the willingness to accept “failure”, first, belies an underlying
transference of responsibility to the patient for not seeking the recommended care, (mental health counseling) and for moving outside the bounds of a clinically defined illness reality (somatizing her illness).

A rational patient adheres to the rules of the sick-role: seeking out medical expertise, giving the body over to be examined and complying with the treatment regimen. When patients deviate at any step in this process they may be judged irrational or responsible for their illness. These maneuvers act to maintain the rationality and coherence of the biomedical world view even while they disqualify the patient’s suffering...(Kirmayer 1988:58).

Furthermore adherence to this view not only disengages the practitioner from the treatment process, it also provides no incentive to question a system that fails to consider the patient’s illness experience.

Reasons to delay treatment: Contrasts in Doctor and Patient Perspectives

Another area of concern is prompt treatment of health problems. Clinicians at the health center expressed a concern that often students do not come to the health center until they have to. Once again we see students and physicians holding different impressions. In this next section I will illustrate how the biomedical perspective legitimizes the views of health care providers.

The Physician’s Views

Their concept of illness is one where they have to be alarmed by their symptoms before they come to see the doctor.(male clinician)

They come in because they’re really having a major problem. It’s not just for health maintenance because I’m sure they rely on their cultural foods and that sort of stuff, but they don’t come in. It’s usually more of a problem that needs to be taken care of and they’re still trying to fit that into their schedule. It’s still not a priority for them. (female nurse)
Students often wait until they are acutely ill before they come into the clinic, then they want a “pill” to make them instantly better. (male clinician)

The doctors tended to hold these views for a variety of reasons. Some saw Asian students as dedicated to schoolwork, others felt biomedicine was perceived as high “tech” immediate treatment and so expected a quick fix when they came in, and others felt these students preferred to self-treat first.

Chinese women are so goal oriented that they won’t come in for appointments because they’ve got something going on. Like I have had women miss appointments, important appointments, because they’ve had a project like a lab project and they can’t leave it. They are so focused on their academic pursuits here, it’s almost like they are narrow minded to that. They need to get this and this and this done in their study time and the health part of it,—-that’s my perception, I’m sure there are other things going on,—- is an aside. (female clinician)

They see the West as high tech and sophisticated, able to cure anything. (male clinician)

When they come in sick I try to find out what they have done about their problem. Students have packed things with them or they ask other students for help. (male clinician)

The clinician’s impression that students postpone treatment as long as possible, was borne out by the students themselves. However, their explanations as to why this was so, paints quite a different picture from that given by the doctors.

The Student’s Views

My allergies started two years ago I didn’t know the system very well and so I didn’t know how to get an appointment and stuff like that and I had a very bad allergy. Finally my advisor brought me to the health center and so actually the problem for me was that I couldn’t go there myself because I didn’t know the system very well. (Japanese female)
The main reason students don't like to go to doctor here is expense. Chinese students always have to balance money versus the severity of the illness. (Chinese male)

I don't use the health center, because I don't know how to and I'm usually not sick. (Chinese female)

I considered going to the health center but didn't really think my cold was bad enough I also didn't know enough about how to access it. (Chinese male)

I have access to a Korean doctor, other Koreans use him too. They feel more comfortable with him he can understand them better than American doctor. Also he knows about Koreans better than American doctors. (Korean male)

Practical concerns like access, expense and utilization of other providers are generally what keep students from using the campus health center. However, as I have illustrated, this differs significantly from the understanding of health care providers.

It is important for me to state here that the health care providers I interviewed at the OSU Health Center, all clearly were dedicated to providing the best care possible for their patients. Additionally, they all expressed their desire to better understand and deal with the issues of cross-cultural medical care. Often however, their intentions were overshadowed by a lack of awareness of the influence of culture and the biomedical paradigm on their world view. Consider the following responses given in individual interviews when clinicians were asked about issues of self-treatment.

I'm dealing with a guy that is diabetic. He came to see me about medicine from China that he wants to take, and it actually it has more side effects and requires a lot more monitoring. I'm trying to get him to switch over to American medicine. It's a bit of a struggle, because he really wants to treat himself with the medicine from China. (male clinician)

Their folk remedies may be something we don't usually think of as a folk remedy, like herbs, plants. They often have
access to steroids, antibiotics, things that can be very powerful. (male clinician)

There are extremes, sometimes there are people who do it and are not harmed by it. Other times they really don't understand what the effects are. A lot of students will come with medicines from their own country, a lot of them are either topical or herbal. Most of them are certainly not harmful although there are certainly cases where they can be. It's difficult to talk them out of taking these things. (male clinician)

These comments reveal a belief that access to pharmaceuticals ought to be contained within the medical community, and that physicians “understand” the difference between harmless “folk remedies” and “powerful” pharmaceuticals, students may not. Implicitly these notions denote the hierarchy of power contained in a health care system where patients in the “one down” position have to rely on physicians, in the “one up” position, for access for pharmaceuticals.

In other cases their comments reveal a hierarchical perception of students and knowledge about health with Americans at the top and international students below.

For the most part our (American) students are extremely sophisticated and have had health classes in school and for the most part that is not true for international students. You say things to them and you realize they have no understanding at all of what you're talking about. If you speak of simple things like peptic ulcer or gallbladder or ovary they really have no concept of where that body part is or how it functions or what the problems might be. (female clinician)

You're really starting from ground zero when you try to explain it because they really have not been exposed to medical terms or health classes in school or to anything. They have no concept and I think that's something that we as providers of medical care have to remind ourselves of because we're so accustomed to the average American who knows quite a bit. (female nurse)
Clearly in some cases there is little recognition that clinical definitions regarding health are cultural constructs representing Western biomedical perspectives and are not meaningful beyond the clinical domain.

Where our American people are very tuned into having a pap smear done yearly the international students are not. They don't even know what a pap smear is or what part of the body it involves or why we do it or that it prevents cervical cancer or what cervical cancer is. I mean that's the kind of information deficit that I think we're dealing with. (female clinician)

In some cases categorize the international students medical knowledge into domains of folk stories or superstitions.

I'm always amazed how people view their bodily functions differently coming from a different culture. They tend to rely more on folk stories or medicines that have been passed down. They come in and they're just worried about all kinds of things, more so than women in our culture. Well obviously because we have more of the traditional or scientific basis for looking at things. So it's real interesting for me to talk with them and try to reassure them that everything will be alright and to try to explain physiological responses. (female nurse practitioner)

This statement seems to implicitly suggest that folk stories and superstitions offer less than adequate explanations for bodily functions.

That these patients are more worried than Americans who have a scientific basis for looking at things. Furthermore, explaining physiological responses, that is, the clinical reality, is part of how you “reassure them”.

Again it's very difficult for them to understand. They are very smart but they really haven't grown up with the kind of medicine or prevention or anything else. Also they have superstitions about medications and what it might do to them.(female nurse)
In other cases clinicians may misunderstand the situation-centered orientation of Asian students who, perceiving themselves as subordinate, take the “proper” attitude.

The intentionally befuddled Chinese student, is a student who is being stubborn about doing something. They can look absolutely helpless when they don’t want to do what you’re telling them. (male clinician)

Finally, while clinicians may demonstrate an understanding of the differences international students present in the clinical situation, they may not feel the impetus is on them to change.

For many students our systems are not so different, but how we approach things may be, for example we found out that many Japanese students are not accustomed to having something put in their mouth, so taking oral temperatures can be offensive to them and that happens right at the beginning of the exam. It’s something that’s going to be done. (male clinician)

I know for some of them the American medical system is quite different than what they are accustomed to. But this is what’s here and we have to teach them how to use this system or adjust to this system, because like it or not this is our system. (female clinician)

Taken in total these statements reflect a belief that biomedicine is powerful and its pharmaceuticals are best dispensed from within the boundaries of the system. International students are conscientious and smart but they do not understand “our” medicine as well as American students who are more sophisticated and learn about health in the school system. International students acquire information from oral traditions. What these students know about medicine is a kind of folk medicine, it is difficult for them to understand Western medicine. Non-compliance can be attributed to stubbornness and superstition. Finally, it is the students who ought to adjust, “because like it or not this is our system”.
These views illustrate several points discussed throughout this paper. First, the notion that students are expected to adjust to "our system" reveals a medicocentric perspective that disregards the complexity of culture and individual differences in favor of a simplified clinical reality. This reductionist perspective is supported by and created from the abstract-bias of Western scientific thought which emphasizes similarities between individuals rather than differences (Jones 1976). Furthermore, it denotes the inequalities inherent in a medical system which has bounded itself with the dominant medical paradigm, and reveals a structural inflexibility which serves to maintain the hierarchy of power within the health care system. Second, it reveals the culturally constructed clinical realities of medical practitioners who remain unaware of the impact of these assumptions on their perspectives and perceptions of health issues concerning international students. Finally, that problems of non-compliance are attributed to the students demonstrates how clinicians transfer responsibility for health care to patients when they are perceived to act irrationally by failing to adhere to the rules of the sick-role (Kirmayer 1988).

In conclusion, I find it difficult to accept the notion that international students suffer from syndromes and disorders as described by previous researchers. Rather I find that it is the effect of envisioning different realities that impacts the delivery of appropriate health care in the cross-cultural medical setting.

Furthermore I feel the obligation to address these issues lies with the providers. International students seeking medical assistance are already coping with illness and the incumbent stresses of getting along in another culture, to further burden them is unreasonable. A reconceptualization of
the relationship between a clinical and patient reality of illness is necessary.

One way of addressing these problems may be to utilize an interpretive model that is aimed at understanding. The primary benefit this offers the cross-cultural medical situation is the establishment of a meaningful context for patient behavior and thus it assists clinicians in comprehending the patient’s model of illness.

Good and Good (1980) have suggested that all clinicians regularly “decode” or interpret patient’s symptoms across medical systems as a part of diagnosing and treating illness. Therefore this model could be readily incorporated into the doctor-patient dialogue that is naturally a part of the treatment process.

PART III  HEALTH CARE ISSUES

In the course of my interviews with international students I found, as have other researchers (Huang 1977; Jensen and Jensen 1983; Williamson 1982; Vogel 1986) that there are many other practical issues which impact the delivery of health care. These include language barriers, access, treatment decisions, and expenses. In the following section I will reveal the students observations concerning these issues.
Communication Barriers

Issues of communication most often means dealing with language barriers. In some cases this may be simply not having enough language to explain the problem.

Some people are very hesitant to go there because they cannot speak English so if they go there they cannot communicate with the doctors. I went there once with a friend because he could not express what was wrong, he had some kind of pain in his legs and was very afraid of some clot in the vein, but he could not talk very well and he didn’t know how to explain what was wrong. (Japanese female)

I went to the health center once for a rash. I didn’t understand anything. I took along a friend to help with English. I don’t know what caused the rash. I used the medicine and it eventually went away, but I haven’t gone back to the health center. (Chinese male)

Language is the biggest problem for international students they don’t understand things. (Korean male)

It’s still hard for me to explain and hard for me to know what the doctor says. It’s so technical a word, she said oh you might have this problem, this one, this one, this one, a little bit of this one, this one, this one but I don’t know any of these words. (Japanese female)

At other times students feel frustrated when trying to translate their understanding of the problem into a language not reflective of that paradigm.

The problem is I was really frustrated that I couldn’t express the feeling very well cause of English. Like,...well, in the stomach. We have a lot of ways of expressing this pain like suku suku, chiku chiku or (others). Every little kind of word has a little different kind of painful and I don’t know why we can say but we, from the very small children we can express, I feel like suku suku or chiku chiku so I cannot use these kinds of words here where they have different language it was so frustrating for me. (Japanese female)

Communication was not perfect, but OK for me. In many cases it’s extremely hard to describe subtle feelings to a
doctor. It's even something that is difficult in Korean and I think it could be dangerous if the doctor just guesses about what was said. (Korean male)

Finally, the ability to communicate goes beyond description and explanation, it figures prominently in issues of trust.

When the doctors talk slowly and try to explain things to me it helps me to trust them more. (Korean female)

Also you will not get so scared of an operation. Because of the way that he talks to you, you slowly build up trust in the doctor. (Chinese female)

When clinicians utilize biomedical terminology in place of lay terms in a cross-cultural medical situation they sacrifice meaningful communication and thus jeopardize compliance and possibly the treatment process.

I have a friend whose doctor gave her a prescription and the dosage was very high and she had a bad reaction to it, she tried to talk with her doctor about it but she didn't understand what he said, so she just stopped taking the medicine. (Korean female)

Furthermore as the following comment illustrates, physicians may undermine a patient's confidence, which may inhibit further successful communication.

It's really stressful when they start talking about a certain disease in the scientific names and that really got me nervous, cause I don't know what they're talking about and they're like, "Oh this guy's got no English". They don't say that but you can feel it sometimes, but for a foreign student I was really nervous about it cause your health is the most important thing. And my English has been really good compared to other students. (Japanese male)

These comments reflect not only the effort required to communicate in a nonnative language, but the problem of understanding. Meaning as I have stated earlier is tied to culture, and language as the carrier of cultural symbols is essential to the transmission of meaning. This becomes
problematic when native and nonnative speakers assume they share meaning because they understand the words they are using. The dilemma arises as a matter of the context the language is used in, which may be misread or misunderstood by the nonnative speaker.

Finally, it is evident here that issues of noncompliance, and underutilization of the health center, as discussed earlier, can be attributed in part to communication problems that may generate fear and misunderstanding.

Gaining Access to Health care

As Jensen et al. (1983) reported, the American fixation with punctuality and matters of time may not be shared by Asian students. Thus the required appointment and scheduling procedures at the Student Health Center may inhibit those already ill from contacting clinicians for assistance.

I caught a bad cold and fever once in the first year I came here. I considered going to the health center but I didn’t know how to use it, so I stayed in bed in my dorm and complained to God. (Chinese male)

I’m not usually sick, but I don’t use the health center because I don’t know how to. (Chinese female)

Even students who have attended orientation may still be reticent to contact the health center, and may rely on those around them to notice their illness and assist them in getting medical help.

I didn’t know the system very well, so I didn’t know how to get an appointment and stuff like that, and I had a very, very bad allergy. Finally my advisor brought me to the health center. I couldn’t go by myself because I didn’t know the system. Apparently there was a meeting to show how to use it but I didn’t understand English very well... orientation takes a long time, three days and we must sit there without knowing
what's going on. I felt kind of bored and didn't listen to them so much. I'm sure they told about that but I didn't remember about it when I got sick and I was hesitating to go there. (Japanese female)

Orientation sessions may need to be changed in order to more effectively deliver important information to international students regarding utilization of the health center.

Additionally this particular story may be illustrative of the desire to amaeru, in which case it would be natural from the students perspective, even though she was quite ill, to wait for a superior to notice how sick she was and take responsibility for getting her to the doctor. As Doi has pointed out, the desire to amaeru “is strongly present in all formal relationships, including those between teacher and student.” This clearly illustrates the relevance of culture patterning in health behavior. Administrators must recognize that “how to” explanations may not go far enough in facilitating delivery of health care to this segment of the student population.

The Decision to Self-Treat

All of the nationality groups I interviewed utilized medications they had brought from home. International students, as with most people, do not usually seek medical treatment at the first indication of illness. Several reasons emerge for this: expense, preference for familiar medicines, time constraints, and fear stemming from the belief that American pharmaceuticals are figured for a larger bodied heavier population.

All Chinese students have their own medicine bundles, they keep things like antibiotics, flu treatments, pain killers, and tranquillizers. (Chinese male)

I have my own medicine to treat colds, some injuries, upset stomach, diarrhea, things like that. Things that do not respond to my treatments I would see a doctor for. (Chinese male)
If I can treat myself I don’t go to the health center, I just get some medicine from Japan. (Japanese female)

I use some medicines from Korea. I was very tired after my second child, I had no physical problems but I felt very weak. I talked with my cousin in Korea who had had the same experience she recommended that I take shark oil and she mailed some to me. I am taking it now and feel better. I didn’t tell the American doctors, they wouldn’t understand. (Korean female)

Some students self-treat with the same over-the-counter drugs commonly used by Americans. Advertising and recommendations by friends, or doctors, can influence their decisions to use these products.

Usually when I get sick I first try self-treatment by going to the store and getting over-the-counter medicines if that doesn’t work or if it lasts longer than a week I go to the health center. (Japanese male)

When I get sick I first try to take care of myself with some things from the pharmacy like at Fred Meyers, if they don’t work then I go to the doctor. (Korean male)

When I get a cold I just get Sudafed™ from the market and I’ll be fine. The doctor suggested I try this one time, so now I always use it. (Korean male)

Well the first time I used American drugs was when I had a cold this winter break. I first [saw] it on the TV and I think well this drug is pretty good and so I take that drug and see if there are any side effects. (Chinese male)

In most cases, students self-treat with their own medicines because they are familiar with them. They have used them at home and know what to expect from them. In addition to familiarity, the issue of efficacy also figures in. Chinese students were the most likely to recognize a difference between Western and Chinese pharmaceuticals.

Those kinds of medicines that we bring with us we always get from the doctor that we are familiar with, or family doctor so they kind of know us very well, every time we get sick
we go to the same doctor... we always get medicines from the doctor we are familiar with. (Chinese male)

I think it's characteristic of the Chinese to trust Chinese medicine more and to trust herbs more. I use Chinese medicine for certain things and American medicine for certain things. I think Chinese medicine is good for internal adjustments and American medicine is good for surgery. (Chinese female)

Chinese herbs are good for things like stress or small illnesses that affect people. (Chinese female)

So many Western medicines have more side effects than Chinese medicines. They kind of treat your illness temporarily and then they have a lot of effect. You take it and you feel a lot better, but then after 12 hours the medicine's effect goes away and you feel the same thing that you felt. (Chinese female)

Chinese medicines go more slowly than the Western ones do but it really treats the root of your illness. But we're talking about catching a cold or cramps, small things. Big things we have to rely on Western medicine, in China even. But for chronic long term things you use Chinese medicine. (Chinese female)

The female Japanese students chose to self-treat with their own medicines because of fears about the strength of American medicines.

I don't take things from the pharmacy here, there's a reputation here of medicines being too strong. For example Contact™ is much stronger here. I heard of a guy who took some and it made him very thirsty and sleepy and it's too strong here. So I ask my parents to send me medicine. (Japanese female)

I think one time I tried one medicine. It was really strong, it had a really strong effect through my body because I'm not used to eat that medicine. Probably the contents or ingredients are more strong ingredients, that's the way I thought. Well because the Western has a bigger body than Asian so the ingredients have to be stronger. It's designed only for Americans not for Asians. (Japanese female)

I think it's more a tendency in the U.S. for doctors to give us very strong medicine quickly. (Japanese female)
Japanese focus group:

Student 1: Some people have told me American medicines are a lot stronger. (female)

Student 2: I know dosage depends on body weight and concentration in the blood. If our body weight is smaller it means we should take less drugs than bigger people. The average American women are much bigger than the Japanese. (female)

Expense

The expense associated with medical care in the United States is another factor affecting the health care behavior of Chinese students in particular.

Main reason students don't like to go to doctor here is expense. Chinese students always have to balance money vs. the severity of the illness. (Chinese male)

When I get sick I eat light, vegetables, drink a lot of water, eat porridge, and go to bed. My system will clean itself out. I don't go to see the doctor unless I have to. It takes time and costs money. (Chinese female)

It's easy and more convenient for us to use medicines from home and also that we think about money, we don't have to pay for it if we have medicines of our own. (Chinese male)

Health Insurance

Related to matters of medical cost is, of course, health insurance. This topic frequently generated many complaints among all the nationality groups I interviewed. Even when students recognized it was for their benefit they still were often unhappy about various aspects of the University health insurance system.

The American College Health Association and National Association for Foreign Student Affairs formulated a joint position statement addressing the issues of health insurance for international students in
March of 1986. They determined that "it is critical for all institutions to require adequate health insurance for all students and dependents and to determine an appropriate minimal standard of coverage in order to reduce the damaging direct costs to students" (ACHA and NAFSA 1988:307). Their policy statement further recommended that universities and colleges require that students demonstrate adequate health insurance or financial resources as a condition of enrollment. Although the intent of this recommendation is to assure adequate medical care for international students, many of the students I interviewed expressed dissatisfaction with the required purchase of medical insurance.

Insurance is a problem. It’s very expensive and not so effective, and OSU insists that we get insurance. (Japanese female)

We have to pay for health insurance and then we have to pay more for doctor and prescriptions. Also I try to avoid going to the doctor I hate that so badly. (Chinese female)

I was invited to the panel of international students from the health center. The most popular issue concerning about the price of the insurance and the cost that we have to pay for medicines. It doesn’t seem like health insurance helps us that much. That’s what we feel, we all feel the same way, that it's not. It didn’t seem fair to us that we have to pay, I mean add it up, it’s expensive enough and we are from the country where you don’t buy health insurance. Not many people buy it, this is expensive enough for us. (Chinese female)

Insurance too is expense. It cost 500$ and doesn’t cover so much. I called my mother and had her get some for me. (Japanese female)

The following segment is from the Japanese focus group dialogue, it was comprised of all women:

Interviewer: You can use Japanese insurance here?

Student 1: Yeah.
Student 2: I shouldn't have changed, I'm sorry I did change. The Department of Education recommend me to change so I changed from Japanese but I think [Japanese insurance] can pay more.

Student 3: I got recommended by the department of International Education to buy it. The problem is when I bought it, it didn't cover [pregnancies], and the OSU policy is that it has to cover when you get pregnant. I [won't] have a baby here, but they said it's a requirement and as long as you are female you have to have it.

Student 1: Still it's so much money and [OSU insurance] only covers 80% and Japanese covers 100%, now I have to pay 20% and the one hundred dollar deductible.

In addition to feeling they are not getting the coverage they would like for the financial expenditure, the maze of paperwork and payments is another area that generates frustration for international students.

I didn't know their system of how to pay. They explained so much, I went to the cashier in the health center. I heard [that] I have to pay for the medication first but actually I don't understand it very well even now. But the treatment and medication are separate. You pay separately, insurance doesn't cover the medicine. (Japanese female)

A paper came to me and I have to sign my name someplace and send it to someplace and I just did it without knowing anything and I got to pay sixty bucks or something like that. It was kind of uncomfortable I wasn’t sure what I was doing, it was a problem. I appreciate what they did to me and I didn't have any bad experience at the health center but the only problem is I don't know how to pay. It's not so clear to me even now, and it's kind of a problem. (Japanese female)

Typically, it would seem, decisions regarding health insurance were determined without fully appreciating the consequences involved for the students. Certainly, health insurance is an important hedge against the fantastic expense imposed by sudden or prolonged illness requiring hospitalization. However, while health insurance may protect medical
institutions for services rendered, the additional burden it creates for some international students remains unaddressed. This again is illustrative of a clinical reality bounded by the dominant medical paradigm that serves to maintain a hierarchy of power within the health care system. Additionally it portrays a medical system that has modeled itself after the capitalistic corporate system that views medical care as a commodity not service.

CONCLUSION

International students seek medical help when acutely ill or for everyday problems when their own ministrations fail. The decision to seek care is often enmeshed in time and resource demands, advice from others and a number of other factors including communication barriers, self-treatment, and financial considerations. These issues are representative of those recognized by many researchers including those cited in this paper (Huang 1977; Williamson 1982; Vogel 1986; Sanford 1987).

Health behavior however, is complex, and often the culturally constructed values and beliefs underlying behavior go unrecognized when studies ignore or discount the role of culture as an important factor in the cross-cultural medical encounter.

Furthermore, if health care providers remain unaware of the influence of their cultural and biomedical perspective, it may impede the delivery of appropriate and/or successful treatment. Thus, the efficacy of biomedicine may be easily overshadowed when clinicians fail to recognize cultural patterning in the illness beliefs and behaviors of patients. Finally, an unyielding adherence to biomedically accepted meanings of health and illness serves only to further obscure the patient's illness reality and may frustrate the physician's treatment regimes.
CHAPTER SIX

CONCLUSION

You are what you know.
At any time in the past, people have held a view of the way the universe works which was for them similarly definitive, whether it was based on myths or research. And at any time, that view they held was sooner or later altered by changes in the body of knowledge. (James Burke 1985: preface)

L. E. Ward’s benchmark presentation describing Foreign Student Syndrome was the first biomedical diagnosis of problems university medical practitioners were seeing in their international student patients. Though certainly there are exceptions, subsequent studies by university medical personnel continue to validate the notion of international students as suffering from psycho-social syndromes and disorders. (Ichikawa 1966; Ray 1967; Zwingmann and Gunn 1983; Gunn 1988; Sanford 1987).

My introduction to this topic of study was through Mary K. Sanford’s article On Being Sick Away From Home. I read this paper prior to undertaking the research for this thesis and at that time her methods and conclusion, that adjustment difficulties are a causative factor in international student illness, seemed reasonable at that time. However, after conducting my own interviews, reviewing the literature on this subject and closely examining what students and health care providers reported to me, that view has changed.

I find that it is the effects of culture, that is, the envisioning of different realities, in similar situations, that affect both patients and practitioners in the cross-cultural medical encounter. This pluralistic perspective equally validates both points of view and attributes problems that arise to misunderstanding. That is to
the lack of familiarity with the others imaginitive universe/reality. (Geertz 1973). I find that to call these problems “cultural adjustment difficulties” or label them as syndromes or disorders portrays international students in an unfavorable manner and is implicitly ethnocentric as it pointedly defines these students as different and therefore responsible for problems arising between patient and practitioner. While some health care providers have attempted to address the role of culture in this setting they often demonstrate a shallow understanding of culture (Ichikawa 1966; Williamson 1982; Sanford 1987; Burak and Knorr 1990; Alexander and Shaw 1991).

In order to grasp the reality of others we must look to the underlying values and beliefs that motivate behavior. Equating culture with reality calls for understanding the culturally derived meanings that individuals use to interpret their reality. “These meanings link people to one another and form the basis of social action” (Lock 1988:5).

The Underlying Dynamics of the Biomedical Perspective

American core cultural values, in conjunction with a biomedical paradigm, formulate a base from which university medical health care providers interpret their clinical reality. Individuality, openness, and direct communication are manifested in the co-participatory doctor-patient relationship. Here clinicians rely on the principle of equality as it sustains a direct open communicative style that reveals a low context, non-hierarchical relationship characteristic of the American medical encounter. The possession of medical knowledge confers status and power on the physician and places him/her in a superior position to others within the hierarchy of the clinic. Here, emulating the corporate model, his/her role is that of analyst and he/she like the corporate executive delegates the performance of tasks to others.
Clinical definitions of illness are derived from a naturalist paradigm that portrays illness in starkly biological and radically material terms. The acceptance of this definition of illness by physicians legitimizes the objectifying of patients and permits diagnosis and treatment to take place as if humans existed outside of society and illness was free of human meaning. The rationality and authority of the medical establishment is maintained by transferring responsibility to the patient for his/her illness if they deviate from a medically defined sick role.

Collectively these premises have been supported and sustained through the political and legal bounding of medicine and through socio-cultural beliefs that give prestige and dominance to the naturalist paradigm and link it to social, political and personal investments that support the biomedical model.

The ubiquitous acceptance of this paradigm as representative of "reality" reveals how such labels as "foreign student syndrome", "uprooting disorder", "migration disease" and "psycho-social problems" might be attributed to international students as a result of their clinical encounters with university physicians.

However, if we accept that the meanings individuals use to interpret their reality are attributable to culture, which provides explanations of what is thought of as "real", then it is possible to understand these labels as representative of a particular perspective rather than describing illness as it is understood by international students.

The Students Perception Of Medical Encounters

Asian international students bring with them to the medical encounter a different paradigm that, for them, provides a definitive view of illness. It also is grounded in meanings learned from cultural experiences. Central to this paradigm is an orientation that places an emphasis on the individual's appropriate place and
behavior among his compatriots (Hsu 1975). These notions of relationship are recreated in a high-context, hierarchical doctor-patient relationship, where physicians acquire the role and status of patriarch and patients presume and depend upon his benevolence and knowledge to take care of them.

In the cross-cultural medical encounter, these views may lead to misunderstandings regarding the ordering of relationships and bring a new perception of medicine as the commercial aspect of medical practice in America shifts the notion of health care from service to commodity. Finally when American clinicians refer students to mental health counselors Asian international students may be left without adequate health care for this is rarely an alternative for the students seeking help.

Conclusion

Clearly medical researchers and other university health care providers are limited in their ability to understand Asian international students in the cross-cultural medical setting because they lack awareness of “the culture-bound clinical reality constructed by the social and cultural context [they] are in” (Kleinman 1980:370). The following comments by James Burke restate this idea in another way,

In all cases of perception, from the most basic to the most sophisticated, the meaning of the experience is recognized by the observer according to a horizon of expectation with which the experience will be expected to fall. Anything which does not do so will be rejected as meaningless or irrelevant (1985:309).

The anthropological views on health care I have presented offer an alternative to empirical research on health and illness. These notions of health care are powerful and of considerable value because they require individuals to step beyond culture-bound realities in order develop a pluralistic perspective that
validates the existence of different illness realities in the cross-cultural medical encounter. One way this might be accomplished is through the introduction of a set of questions used by the physician to elicit the patient's view of the illness experience. These may be incorporated into history taking or other routine clinical activities. In cases where language is a problem, techniques already in place at the health center could be applied in this instance as well. For example, having these questions available on a handout in the students' language, using interpreters, requesting that the student bring a friend who can help translate, and planning more time for these appointments.

Once in place, the physician who was “having a bit of a struggle” getting a Chinese student to take an American medicine for diabetes, might start out by seeking to understand why the student feels strongly about taking his own medicine, and what he thinks about the American medicine. How does he think taking the American medicine will change things? How will the Chinese medicine help him cope with this illness? How does this problem affect other aspects of his life? What does he think led to the development of this problem? How does he think the physician can help him? There is no simple set of questions that can be used to elicit stories and experiences from patients, however these examples offer suggestions. Answers to questions like these will undoubtedly lead to more questions and answers which will serve to educate the physician in understanding the patient and he/she in turn can use that information to help educate the patient. This sort of exchange of information and understanding will surely facilitate communication and enhance the delivery of health care for both the patient and the clinician.

The qualitative approach I have used for this thesis research has allowed me to gain insight into the cross-cultural medical encounter and attain a deeper level of understanding. The vast majority of the literature describing psycho-social
disorders in international students misunderstands the role of culture and implicitly portrays these students in an unfavorable manner. This thesis illustrates how an anthropological perspective allows for the reconceptualization of these encounters by recognizing the diverse ways individuals interpret their realities.


APPENDIX
FOCUS GROUP GUIDELINES

1. What has it been like for you living in the US?

2. How has your health been since you've been in the U.S.?

3. What medical problems or health concerns have you had since coming to the US?

4. What sort of things affect your health? What do you do when you get sick, how do you deal with it?

5. Have you seen any American doctors, nurses or other healthcare providers since you have been in the US?

6. Are there times when you would prefer to use medicine from your own country rather than seeing an American doctor? When would you do this?

7. How do you feel about the medical care you have received here?

8. How do you compare the medical treatment you have received here with the treatment you have received at home?

9. When did you go to the Health Center for the first time? Did you know how to make an appointment?

10. How did you learn about the Health Center?

11. How do you think your ability to communicate affects the medical treatment you receive? Are there other things that affect the medical care you receive here?

12. What did you think it would be like for you to see an American doctor the first time? Was it what you expected?