ABSTRACT OF THE THESIS OF

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The doctor-patient relationship is one of the most unique and privileged relations a person can have with another human being, and having access to a well-developed and effective association is important for the experienced and objective quality of health care. Yet, over the past few decades a number of cultural barriers and structural trends have converged, reducing the ability of patients to have this archetypal relationship with physicians.

This thesis intends to explore the barriers that affect this professional relationship in Bolivia and provide possible solutions. The cultural barriers I have selected to focus on are: racial concordance of the doctor and patient, language barriers and medical beliefs. The structural barriers that seem to have the most impact are: the decline of primary care physicians, access to healthcare services and the organization of the medical practice. After completing a pediatric health medical internship in Bolivia, which inspired this thesis topic, I have grown as a student, a future culturally sensitive healthcare professional, and as a person. I hope that it can also serve to inform others of the real challenges faced in Bolivian and worldwide health care today.

Key Words: Doctor-patient relationship, barriers, Bolivia

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Cultural and Structural Barriers that Affect the Doctor-Patient Relationship: A Bolivian perspective

by

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I understand that my project will become part of the permanent collection of Oregon State University, University Honors College. My signature below authorizes release of my project to any reader upon request.

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Jessica Diane Fowler, Author

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CHAPTER 1

Introduction

The field of medicine attempts to bridge the gap between science and society. It allows scientific knowledge to be applied directly to human health and well-being, which is the foundation of clinical practice. Within this area of health care, the role of the doctor is that of an important agent through whom this scientific understanding is expressed. Nevertheless, the sphere of medicine encompasses something greater than the sum of our knowledge of this age old science. It is more than sickness, disease, treatment and prevention. Medicine concerns the experiences, feelings, and interpretations of human beings often in extraordinary moments of fear, anxiety, and doubt. In this extremely vulnerable position, it is the relationship a patient has with a doctor that can make all the difference in quality care, and ultimately conveys trust in the medical profession (Working Party of the Royal College of Physicians, 2005).

The doctor-patient relationship, ideally, is one of the most unique and privileged relations a person can have with another human being. A patient to a doctor is at times like a dependent child, an eager student, or a friend needing advice, help, sympathy, understanding and hope. An ancient physician, Charaka, once said, "A good physician nurtures affection for his patients exactly like the mother, father, brothers and kinds. The physician having such qualities gives life to the patients and cures their diseases" (Sharma, 2001). This teaching relationship is the basis of calling the physician “doctor”, which originally meant “teacher” in Latin, whereas the word “patient” is derived from *patior*, or “suffer” (Etymology Dictionary Online, 2008). Hence, a physician should not

be limited to solely the diagnosis and treatment of their patients, but s/he should also educate and encourage them in their time of need.

Having access to a well-developed and effective doctor-patient relationship is important for the experienced and objective quality of care. Yet in today's society it is easily argued that this ideal association between a doctor and patient is recurrently taught with an unequal power given to the physician than a mutual, two-sided rapport built between the parties. The incredible advancements in the medical field along with the ongoing progression of humanity over the past few decades has elucidated the fact that a number of cultural barriers and societal trends have converged, ultimately reducing the ability of patients to have this archetypal relationship with physicians (Hughes, 1994). It is important to note that these barriers are not only impacting the economic-privileged countries that practice Western medicine such as the United States, but also poverty stricken nations. Being able to recognize these cultural and structural influences on health care practices and ultimately how they affect the doctor-patient relationship is of vital importance in order to better understand what can be done to prevent the further decline of this priceless bond. Moreover, it is imperative to examine what has shaped their formation within the health care field and recognize methods of deterrence, if not positive progression of their influences on the professional relationship for the benefit of world-wide medical advancement.

I recently completed a ten week pediatric health medical internship through the Child Family Health Organization in the capital city of La Paz, Bolivia. I was able to work alongside countless Bolivian practitioners and patients doing pediatric

consultations, pre- and post-partum check-ups, delivering babies and assisting in surgeries. I took notice of how the physicians and patients interacted with one another, and how these encounters could have occurred more effectively, perhaps resulting in an increased number of improved health care outcomes and a higher level of satisfaction. As weeks went by, I became conscious that the cultural and structural barriers impeding effective doctor-patient relationships in Bolivia were interchangeable with those of the United States health care system: Hindered communication due to language barriers, conflicting medical beliefs and, of course, financial obstacles to receiving the optimal care necessary. Hence, I decided that I wanted to examine these barriers in order to comprehend to what extent cultural competency and infrastructure impact health care.

This thesis is intended to explore the cultural and structural barriers that currently affect the doctor-patient relationship in the third-world country of Bolivia. I will employ the use of narrative exploration and reflection of my own personal experiences working in medical hospitals and clinics related to these barriers in the country's health care system. Furthermore, I will incorporate previously conducted research to investigate and analyze the current dilemmas facing quality health care due to these barriers and discuss possible ways to impede these factors from diminishing the doctor-patient relationship.

CHAPTER 2

Background Information

Defining the "Doctor-Patient" Relationship

The doctor-patient relationship, or more specifically the interaction between the two parties, is a central process in the practice of medicine. Talcott Parsons was the first social scientist to theorize the doctor-patient relationship and according to him, "the physician's role is to represent and communicate [information about illness] to the patient to control their deviance…with physician and patient being protected by emotional distance" (Hughes, 1994).

Although Parson's view includes the two individuals being protected by emotional distance, a good doctor-patient relationship should have some exchanged sentiments in order to build a high-quality connection. From a modern physician's perspective, the rapport begins while s/he becomes accustomed to the patient's symptoms, concerns, and values. Subsequently, the physician examines the patient, interprets the symptoms, formulates a diagnosis, and then proposes a treatment and follow-up plan to which the patient agrees upon. Additionally, it is important that the physician consider the patient's lifestyle and their "healthy" demeanor. This includes life attributes such as family, work, stress, habits and beliefs, since these often offer fundamental clues to the patient's condition and further management of the problem.

This relationship can also be analyzed from the perspective of ethical concerns, in terms of how well the goals of beneficence, autonomy and justice are achieved from the encounter (Coulehan & Block, 2006). This aspect of the doctor-patient relationship is

complicated to scrutinize given that in diverse societies, periods and cultures, different standards may be allotted to different priorities. A great example of this outlook on the relationship is the increased autonomy in decision making by the patient in regards to their personal medical concerns (Sharma, 2001). The reliance of the patient on the doctor to make all the decisions is a concept of the past in Western medicine.

Taking into consideration these elements of the doctor-patient relationship, it is certain that communication between the patient and physician is the primary characteristic which ultimately helps define how successful the affiliation can become between the two individuals. Because much of medical care relies on information management, collection of accurate and comprehensive patient-specific data is imperative and is the basis for proper diagnosis and prognosis. Furthermore, involving the patient in treatment planning, eliciting informed consent, providing explanations, instructions and education to the patient and the patient's family requires *effective communication* between the mentioned parties. According to Schyve, "effective communication is communication that is comprehended by both participants; it is usually bidirectional between participants, and enables both participants to clarify the intended message" (Schyve, n.d.). In the absence of comprehension, the provision of health care ends, or proceeds with errors, poor quality and risks the patient's safety.

Effective communication ultimately leads to an enhanced doctor-patient relationship resulting in satisfaction with the encounter by both parties and thus improved health care outcomes. For example, without successful communication, the patient may not feel comfortable telling the doctor every aspect of the problem or how it might relate to his lifestyle choices. In turn, the doctor's ability to make a full assessment is

compromised and the patient is more likely to distrust the diagnosis and proposed treatment. Therefore, the quality of the doctor-patient relationship is important to both individuals. The better the relationship in terms of mutual respect, trust and shared values and perspectives, the more quality information will be transmitted in both directions.

Hence, for the purpose of this thesis the barriers discussed to the connection between doctor and patient will be based for the most part upon the hindrance of *effective communication* and understanding and thus the decline of the relationship.

Bolivian Culture

The Bolivian nation is a part of one of the richest cultural treasures of the Incan civilization. With more than half of the population still living according to traditional ways, it's modern culture is heavily influenced by the centuries-old traditions handed down since the time of the Incan empire. While this ancient civilization has played a great role, the enduring legacy imprinted upon the country by the Spanish conquest of the 1500's also has made a lasting impression (Destination 360, accessed 04/2008).

Today Bolivia is one of the least developed countries in Latin America, with over 60% of the population living in poverty. The Bolivian people originated from predominantly indigenous groups coming from a variety of tribes strung across the Andean region. These include the Quechuas, Aymaras, Chiquitanos and Gauranís, and at present the country is one of the only places that has preserved the majority of its indigenous populace. These Indians have a distinct appearance: They are of short, stocky build, have darker colored skin, and many wear brilliant weavings and traditional

clothing. Most of the indigenous population lives in rural, isolated areas of the country, eking out a meager existence in the parched highlands of the Altiplano where they have little access to basic services such as health care or education. In the cities they face racism and are looked down upon by the *criollos* (descendants of former Spanish colonists) who are the wealthiest people in the country, despite the fact that the indigenous and *mestizos* (a person of mixed European and Indian ancestry) make up over 80% of the population. Consequently, many people speak Quechua (30%), Aymara (20%) or one of the other native languages, even though Spanish is the official language of the country (UNICEF, 2008). The fact that many of the indigenous speak languages other than Spanish makes it difficult for them to attend school and obtain higher paying, skilled jobs. Thus, most of them continue to work as subsistence farmers, traders, artisans, or miners; occupations that currently pay very little and offer few opportunities for advancement. This economic inequality has only increased the racial tension between citizens of European decent and indigenous communities.

The integration of indigenous groups with the Spaniards, along with less represented ethnicities, has created an amalgam of diversity in the cultural patterns and belief systems in the region that are observed today. For example, a majority of the population adopted the Spanish religion. Today, approximately 78% of Bolivians are Roman Catholic and 13% Protestant, although a fusion of the contemporary church teachings and traditional indigenous beliefs is not uncommon. Another important feature in Bolivian society is the centralized view of the family. The Bolivians take pride in their history and communities, and it is important to them to pass these values on to their children. They spend a great deal of time interacting with one another, members of the

extended family and neighbors. Families are usually very large, with the average number of children per household around four, although in the rural communities an average of six is not unusual (UNICEF). This in turn has led to an increased amount of children workers and pan handlers in order to help support these large households.

Although Bolivian diversity adds cultural richness to the area, sadly it is at the root of many political and social incongruities which have plagued the country in recent decades. After tearing itself away from Spanish rule in 1825, the country has experienced more than 190 failed governments, with the average government lasting less than a year. This unstable political system has done little to help the people of Bolivia, a result being the extreme poverty of the nation. In 2005, Bolivia elected Evo Morales, the country's first indigenous president, who has promised to bring social justice to the country and end discrimination. This seemingly progressive stride however has stemmed a majority of the latest political turbulence from the wealthier populations. Moreover, Bolivia has to deal with the unbridled coca production which is the third largest in South America, abject poverty and escalating social turmoil (Destination 360, accessed April 2008).

CHAPTER 3

Methods

The inspiration for this project stemmed from my participation in a pre-medical internship in La Paz, Bolivia. There I had the opportunity to gain valuable insight into the importance of the doctor-patient relationship while working alongside physicians and resident students in local hospitals and medical clinics. Immediately I began to notice differences in conduct, regulations and personality clashes occurring between the physicians and patients. I started wondering how these incongruities arise, and what could be done to make the doctor-patient interactions more effective.

Information for writing this thesis was gathered by first conducting a review of the literature in order to determine which cultural and structural barriers have been known to affect the doctor-patient relationship. It was important to identify these factors so that I could make direct comparisons or contrasting statements on how each one had an affect on this professional relationship in the Bolivian health care setting. The cultural barriers I have selected to focus on are: 1. racial concordance of the doctor and patient; 2. language barriers and; 3. medical beliefs. The structural barriers that seem to have the most impact are: 1. the decline of primary care physicians; 2. access to health care services and; 3. the organization of the medical practice. Although there were other cultural and structural barriers that were prevalent in the literature which had an affect on the doctor-patient relationship, I chose to narrow my research to focus on those topics strictly mentioned above. The reasoning for this is that I feel I was able to witness these select few having the greatest impact on the professional relationship in the Bolivian health care setting and therefore could add the most personal insight.

The next step was to research current literary information regarding these cultural and structural barriers specifically within the Bolivian health care setting. This was done using a variety of written texts, online journals and government-funded websites. To gain further insight, I interviewed three Bolivian physicians, a resident student and numerous ordinary citizens to gather supporting or contradictory data to the literature-based findings. All of the people chosen to be interviewed were of Spanish decent due to the fact that many of the indigenous were unwilling or unable to speak with me because of the language barrier (the interview questions can be found in the Appendix). Finally, I was able to incorporate my own personal experiences and observations working in the Bolivian hospitals and clinics into the discussion using narrative exploration. During the ten week pediatric health internship I spent 400 hours working alongside numerous physicians, medical personnel and patients. Hence, in addition to gaining valuable medical experience, I was able to observe doctor-patient verbal and non-verbal interactions in a variety of medical settings and situations. I would take notes during consultations if anything sparked my interest pertaining to cultural or structural barriers and would ask the physician for clarification of incidents or behaviors I witnessed to improve my understanding.

There are many limitations to this thesis topic. For one, research done in the area of the doctor-patient relationship specific to the Bolivian health care system is deficient. Hence, much of the theoretical background information concerning the doctor-patient relationship is based upon findings in the United States. However, the fundamental data can be applied in regard to the Bolivian health care system quite fittingly. Secondly, the narrative aspects and personalized outlooks of this thesis are results of my own

experience abroad and thus are subjective viewpoints. I observed doctor-patient interaction in a handful of public hospitals and clinics in or near La Paz, which are only a small representative of the entire Bolivian health care system.

CHAPTER 4

Cultural Barriers

In today's multicultural societies physicians are increasingly confronted with patients from different cultural backgrounds. The profound evidence of health care disparities across ethnic and racial lines as well as cultural impressions on health care practices is too impressive to overlook. For example, results of a number of studies conducted indicate that there is more misunderstanding, less compliance and less satisfaction in intercultural medical visits, compared to intra-cultural encounters (Shouten, 2006). Therefore, it is of vital importance that a physician is able to understand that a person's culture is not merely difference in dress, etiquette, and diet, but also and most profoundly, about what really matters to people; it is what people believe, their ethics and values, and their heritage (Kleinman, 2006). This capability in the area of health care is termed being *culturally competent* meaning, "the ability of a health care provider to deliver effective services to racially, ethnically, and culturally diverse patient populations"(Fernandez, 2004).

Previous studies have shown that being able to understand the patient and his/her cultural values is of critical importance in order to build their trust and ultimately lead to effective communication between the patient and physician. For example, one cultural aspect that emerges in Bolivian healthcare is the importance of family in medical follow-up treatment. Unlike the individualistic culture of the United States where people see themselves as independent of groups, in collectivistic cultures, like Bolivia, the self is seen as part of the group (Schouten & Meeuwesen, 2006). Thus, Bolivians are more concerned with a group prevailing, which is usually the family unit, than what is best for

one member. As a result of this collectivistic-oriented outlook, health care goals of an individual might not always be met. For example, if a doctor tells a mother that her child is calcium deficient and needs to be drinking milk, the chances of this being put into action are slim to none because nobody else in the family drinks milk. In a situation such as this, the doctor needs to have the entire family involved in treatment and future prevention to have any affect on the individual patient. (This can also be rooted in poverty and limited public health efforts, but for the sake of the thesis topic, we will group all of these under cultural aspects). Therefore, these differing cultural values, although seemingly inconsequential, are able to have a significant affect on treatment and prevention, and thus the doctor-patient relationship.

Racial Concordance between Doctor and Patient

From the earliest periods in history, divisions across racial and ethnic lines are customary in almost every sector of society, including healthcare. These disparities in the medical field today have most likely emerged as a result of a historic, social and economic inequality, where healthcare in the past was decidedly allocated on the basis of race, social class and ethnicity (Agency for Healthcare Research and Quality, 2003). In today's society, racial concordance between doctor and patient can be a major factor in the quality of care received and the overall effectiveness of the visit as evident to the patient and physician respectively. Due to experiences of discrimination in a society, whether real or perceived, minority patients are more likely to bring preconceived discriminatory notions to the clinical encounter, which are likely to influence their attitudes and behaviors towards a physician of a non-concordant race. Furthermore,

healthcare providers, like all other individuals, can be easily influenced in racial and ethnic attitudes by broader social trends. A study done at Johns Hopkins University which attempted to see if minorities in the United States felt discrimination when accessing health care found that "African Americans, Hispanics and Asians in the U.S. remained more likely than whites to perceive that: 1) they would have received better medical care if they belonged to a difference race; and 2) medical staff judged or treated them with disrespect based on their race/ethnicity" (Johnson, 2004).

Not surprisingly, this issue of racism and perceptual bias is witnessed in all sectors of Bolivian history. Because of the high percentage of indigenous people in Bolivia, they do not in actuality comprise the "minority" population of the country. However, since most still adhere to the traditional way of life and have not integrated fully into the urban lifestyle, the rest of the population tends to disdain them. Furthermore, a large percentage of the indigenous live a life of simplicity or even poverty and are more than likely uneducated. Hence, the urban and upper classes deem the indigenous population according to this stereotype, similar to minorities in other countries.

This inherent tension in attitude towards the indigenous population is evident in the healthcare system in Bolivia. As stated in Ann Zulawski's book (2007) titled "*Unequal Cures*" regarding the disparate medical treatment of the indigenous population in the first half of the twentieth century: "On the one hand doctors, like other members of the elite, maintained that native Bolivians were responsible for holding back national progress…Although doctors didn't say it, the native population also posed a problem of identity (pg. 29)." Doctors and politicians would offer varying explanations for the

nation's ill health, since the country was constantly plagued with tropical sickness and varying diseases during this time. One way or another, they linked physical sickness to ethnicity and race to national malaise. Zulawski goes on to write an entire chapter about the famous Bolivian doctor, Jaime Mendoza, who refused to prescribe different treatments for indigenous people; rather he believed that "Indianness" made them unhygienic and likely to fall ill (Zulawski, 2007).

Unfortunately, much of the discrimination of the indigenous described previously is still relevant in their acquisition and the quality of health care received in the present. Almost all university-accredited physicians practicing in the public and private sectors of health in Bolivia are of Spanish decent, while ironically approximately fifty five percent of the country's population is of indigenous background (UNICEF, 2008). Sadly, the physicians perceive their indigenous patients as being less intelligent, more likely to live inhumanely and more likely to be non-compliant than Spanish patients (Dr. J. Borda, personal communication, March 7, 2008).

> *While working with physicians of Spanish-decent in Bolivian hospitals, I heard them speak condescendingly to the indigenous patients. One doctor in particular would explain to me how the natives viewed the world differently. For example, they believe that the sun rotates around the earth because that is what they see ensue every day from sunrise to sunset. He would go on to explain that the indigenous have a hard time grasping things that they cannot see, which is one reason why they do not trust physicians and modern medicine because in reality illness is hard to witness occurring. He finished this conversation by concluding that the natives were uneducated and full of ludicrous notions altogether. Therefore, this discrepancy between the Spanish and the indigenous in the health care setting is still present.*

Consequently, encounters with indigenous patients are likely to differ from patients with the same ethnicity and cultural beliefs as the doctor because people from other cultures are more likely to hold different beliefs of health, illness and

communication. This fact has obvious implications to a strong doctor-patient relationship. Again, if the two cannot build some sort of confidence and find common ground, the medical visit will have an unsatisfactory result. Due to the long history of racial discrimination between the indigenous and Spanish, change will be hard to come by until both parties are willing to embrace cultural competency.

What can be done to improve the relationship?

Being able to reduce these disparities as a result of ethnic non-concordance and resolving how they affect the doctor-patient relationship is vital to the equal and humane treatment of not only the indigenous Bolivian culture, but everyone for that matter. It is clear that the greater impediment of this theme lies in increasing the access to basic human rights. However with this initiative aside, there are other ways to promote a more effective relationship.

One purposed solution is to increase the number of ethnically diverse physicians practicing medicine and therefore decrease the cultural gap between doctor and patient. This problem is also evident in the United States medical school system; despite efforts made, only 12% of U.S. medical school graduates and 6% of practicing physicians are of a minority background, compared with 25% of the of the total U.S. population (American Association of Medical Colleges, 2007). Similar to the situation in the U.S., an attempt to boost the number of well-prepared ethnically diverse students remains essential in places such as Bolivia as well. In this developing nation, however, this solution will be a slow and tedious process given that much of the *mestizo* and indigenous populations do not finish secondary schooling.

A second and more plausible solution is to decrease the effect of this barrier by teaching current Bolivian doctors to be culturally competent towards the indigenous patients. First, providers should be able to keep an open mind, leaving preconceived notions, stereotypes and bias aside. It is essential that a physician have some cultural knowledge of the patient and be in tune with the patient's level of acculturation to achieve a high-quality doctor-patient relationship. Furthermore, expanded language and culturally sensitive capabilities are important, which we will discuss further in the following sections (Schouten, 2005). In sum, awareness of cultural differences should be used to educate a racially non-concordant physician about the best approach to patients from different ethnic backgrounds.

The Language Barrier

A famous physician, humanitarian and teacher, Sir William Osler, who is known to have a distinguished reputation for his work at Johns Hopkins and Oxford, was an exemplary doctor when it came to treating a patient and teaching a student. He wanted doctors not only to give the patient their best, but to build a relationship with that person. He was known for saying, "If you listen carefully to the patient they will tell you the diagnosis" (Wiliam Osler, accessed April 2008). His outlook on the doctor-patient relationship demonstrated the extreme importance of communication between the two parties. Keeping with the theme of cultural barriers, an obvious hindrance to this professional relationship is the often-encountered lack of language comprehension between doctors and patients belonging to different ethnic or racial groups. In order to provide safe, high-quality health care it is necessary to overecome this barrier to have

effective communication with patients and their families. Research has shown that there is greater misunderstanding, less compliance and less satisfaction in intercultural doctor-patient encounters than in intra-cultural consultations. Moreover, health care providers state that consultations with ethnic minorities are often emotionally demanding because of the energy required to communicate and often they find patients' reasons for visiting unclear (Shouten & Meeuwesen, 2006). There seem to be three key factors as to why language can be a barrier to the doctor-patient relationship in Bolivia due to the hindrance to effective communication: 1) non-concordant languages spoken by patient and physician; 2) illiteracy of patient and; 3) low health literacy.

What is precisely lost in the communication process across a language barrier remains unclear; nevertheless, it is apparent that language differences can create an obstacle to effective interaction in every ethnically diverse population. When doctors and patients do not speak the same language, the relationship the two parties can form is distressed from the beginning. This problem plagues the Bolivian health care system in particular due to indigenous languages that are still extensively used by the rural populations. As previously discussed, approximately 50% of the country's population speaks one of the indigenous languages as a first language (UNICEF). Although some are also able to speak Spanish, bilingualism is less common in the rural areas away from the cities. An anesthesiologist I was fortunate to work with in a rural clinic, Dr. Juan Borda (personal interview, March 11,2008), explained to me, "There are no doctors who speak Aymara (one of the widespread indigenous languages) in this clinic, but we always have a nurse working that does. A few of us doctors can speak some basic words but that is all." Hence, it is difficult for doctors without knowledge of indigenous dialects in

Bolivia to communicate with many of their patients due to the various languages present in the country.

Previous research done in the U.S. regarding language discordance between English physicians and Spanish-speaking patients has found that patients are more likely to report better interpersonal processes of care when their physician has a higher self-rated language ability and cultural competence (Fernandez, 2004). For example, contrary to thoughts that Spanish-speaking patients are less satisfied with their care when seeing a non-Spanish-speaking physician, studies have unveiled that physicians who are fluent in Spanish are more likely than their less fluent colleagues to elicit their patients' problems and concerns. Even the use of interpreters in language discordant encounters did not enable physicians with limited or no Spanish ability to extract valuable information from the patient as well as Spanish-speaking practitioners. In these cases, "physicians made fewer facilitative remarks and were more likely to ignore patients' questions, and patients were less likely to ask questions or to express their concerns compared with patients speaking directly to their physician"(Fernandez, 2004). During my time in the Bolivian hospitals, I witnessed many medical visits where the patient did not speak Spanish as a first language, so noticeably they would just listen to the doctor without verbally contributing to the encounter. A few of the doctors would try to articulate the important details of the visit in crudely translated Quechua or Aymara, but this was an exception to the norm. Usually the patient would nod his/her head, gather their belongings and children and leave the consult room, without murmuring a word back to the physician.

In addition to verbal language hurdles, patients might not be able to read, or they read very little, even in their native language. This barrier not only leaves the patient confused, but also the physician can become very frustrated. Being able to read is of utter importance in regards to quality of care received by the patient. For example, if a doctor writes a prescription and the patient goes home and does not remember how or when to take the prescribed medication, the situation could become very dangerous for the patient's health. This dilemma can by compound if the patient lives in a rural village and had traveled far from home to receive the medical care, or itinerant physicians were in the area and have moved on (Faux, n.d.). Situations like these are not uncommon in developing countries like Bolivia and solutions need to be implemented so that people who cannot read well or are illiterate can still receive the highest quality of care available.

A third obstacle to comprehension and understanding between doctor and patient, even if they do speak the same language, is the low health literacy of the patient. Health literacy includes, "the ability to understand instructions on prescription drug bottles, appointment slips, medical education brochures, doctor's directions and consent forms, and the ability to negotiate complex health care systems" (Health Literacy, 2008). Thus, being health literate requires a complex group of reading, listening, analytical, and decision-making skills, along with the ability to apply them to health situations. When language and cultural barriers are identified between physician and patient, the physician usually explores to what degree the patient can understand his/her oral and written explanations. Contrarily, when the two individuals speak the same language and are of the same culture, often the physician – in absence of questions – believes that the patient comprehends everything communicated during the encounter. Frequently the doctor

realizes belatedly that the patient, although generally literate, could not understand the medical terminology and often times complex instructions (Schyve, n.d.).

What can be done to improve the relationship?

In order to curb the effects a language barrier has on the doctor-patient relationship in Bolivia, solutions must be found that diminish communication disparities caused by linguistic, written and/or comprehension obstacles. In this multilingual, multicultural society, providing safe, high-quality health care requires overcoming these three barriers to effective communication with patients and their families.

In past studies physician ethnicity has been shown to strongly correlate with both language and cultural competence (Fernandez, 2004). Thus, a solution to the non-concordant language obstacle between Bolivian physicians and their indigenous patients could be to increase the number of ethnically diverse physicians. Furthermore, the medical education in Bolivia should emphasize the development of language skills in indigenous languages in applicants because of the high percentage of speakers, and skills in cross-cultural communication for all students and residents (Fernandez). This would augment the pool of linguistically and culturally competent clinicians available to assist the non-Spanish speaking population of Bolivia.

Another dimension of incomprehensibility is the written language barrier. Because many of the poor have few educational opportunities, this obstacle in particular was very apparent in the Bolivian clinics and hospitals, predominantly with respect to prescription directions and information, as previously mentioned. Aside from the lack of

basic education which the country needs to address, there are steps that can be taken in the medical setting to ensure accurate understanding of written directions by the patient. For example, many of the doctors I accompanied in the clinics would make sure to not only write the prescription directions such as "4X per day," but they would go as far as writing out "6:00am, 12:00pm, 6:00pm and 12:00am." The two seconds it took to write out times the patient should take the medication added clarity to the direction, which was easily seen in the patient's facial expressions in response to the doctor's explanation. Furthermore, it has been found that the use of specially designed pictograms can facilitate comprehension of prescription information by low-literate patients by enhancing their ability to recall medical instructions (Houts, et al, 1998). An example of such a form can be viewed in the Appendix.

> *In most of the pediatric clinics I worked in, pictogram forms were used quite often in cases where children had anemia to pictorially show the parents how often and what types of food their child should be eating. Also, the form had information on how and when to incorporate nutritional supplements into their diets. These forms seemed to be well received by the patients because their eyes would light up when they saw the form. They seemed to appreciate that the physicians and we students were concerned about their understanding and comfort.*

Hence, if physicians use techniques such as those above to help ensure low-literate patients understand written instructions, it demonstrates that they are concerned about their patients' health and well-being, which ultimately can strengthen the relationship between doctor and patient.

The obstacle of low health literacy is not only a problem in Bolivia, but is prevalent all over the world. This communication problem is based on a few key factors: lack of educational opportunity, learning disabilities, cognitive decline in older adults and

low reading ability (Health Literacy, 2008). Therefore, to overcome this obstacle doctors need to be conscious of their word choices, using layman's terms to describe everything as simple and clearly as possible. Furthermore, physicians should question their patient's to confirm they are leaving the visit with an accurate perception of everything discussed. Taking active steps to triumph over this problem in the health care setting will lessen confusion and promote better healthcare outcomes, which can fortify a lasting doctor-patient relationship.

In conclusion, language abilities —and cultural competence skills distinct from language—matter in health communication. Due to the amalgam of *criollos*, *mestizos* and indigenous inhabitants, the Bolivian health system will need to ensure that physicians have the appropriate skills for effective communication to improve the patient-physician relationships with the obstacle of the nation's diverse ethnic and socioeconomic population.

Differences in Medical Beliefs

As previously discussed, the relationship between doctor and patient is highly dependant on effective communication and reaching a common understanding. However, when the two parties have different views on medicine, this balance can be difficult to achieve. The most widespread basis for dissimilar medical beliefs is the practice of traditional or alternative medicine in an epoch of progressively modern medicine. This idea of medical pluralism is a common feature in the Bolivian healthcare system, which consists of three overlapping sectors: the folk sector, traditional sector and professional sector (Bruun & Elverdam, 2006).

The folk sector is connected to the home where sickness is first recognized, where treatment using home-remedies are discussed and put into practice. This at-home treatment option is used and up to 60% of all sicknesses are taken care of in this way only. If this treatment proves to be unsuccessful, further action may be sought in the other two sectors: the traditional sector and the professional sector (Bruun & Elverdam, 2006).

The traditional sector consists of healers who practice what is known as traditional medicine. This type of medicine has a very long history, as it is derived from the ancient populations of a region, and can be defined as, " the sum total of the practices based on the theories, beliefs and experiences of different cultures and times, often inexplicable, used in the maintenance of health, as like in the prevention, diagnosis, improvement and treatment of illnesses" (Firenzuoli, 2007). Traditional medical systems (TMS) have been used as primary medical care until recently in countries that have large indigenous populations, such as Bolivia, due to their deep-rooted traditional beliefs. This cultural groundwork and widespread use of TMS have been increasingly questioned by the present dominance of the professional sector, consisting of Western medical practices and educated professionals, such as medical doctors. The discrepancy has been principally based on the effectiveness of TMS use, since the majority of traditional medicines find foundation in magical and spiritual beliefs. (Firenzuoli, 2007)

> *One afternoon while the pediatrician and I were doing rounds in a rural hospital outside the city of La Paz, we came across a 2 year old boy in bad health. The week before he had came into the hospital and had been diagnosed with severe diarrhea and a bad cough due to an upper respiratory infection (URI). The doctor prescribed antibiotics to help with the problems. After explaining to the mother the dosage and regimen of the medications, the indigenous mother hoisted the boy in a blanket over her shoulder and left the consultation room. Now, standing in front of the boy, he appeared much worse than before, which was the cause for his admittance to the hospital. His medical chart informed us that in addition to the diarrhea and URI, the boy was now fighting for his life due to carbon*

> *monoxide poisoning. The mother had built a fire, put a blanket over the boys head and forced him to inhale the smoke fumes, as this was an ancient custom to cure a cough.*

Because of the immense indigenous population, Bolivia's health care system is invaded by this cultural barrier in particular. In Ann Zulwski's book (2007) titled "*Unequal Cures*", she discusses how Bolivian doctors in the 1920's believed that the indigenous lifestyle made natives resistant to conventionally prescribed medicines, and therefore they made cures to suit their "backward, cultural practices (pg. 33)." A large percentage of the indigenous populace still adheres to these traditional ways of medicine using herbs and curing rituals principally based on superstitions and myths, while the Spanish-descendant populace, including physicians, has advanced into the realm of contemporary medicine (Bruun & Elverdam, 2006).

This dissimilarity has indisputably challenged the medical beliefs between the two populations, ultimately burdening the doctor-patient relationship in two principal ways. One perception is that many Bolivian practitioners are ignorant of traditional health practices. This ignorance makes them less effective agents for improving the health of their indigenous patients (Bastien, 1994). The other outlook is that the patients are uneducated concerning the benefits of modern medicine and the limited extent to which traditional rituals are truly advantageous to ones health. These attitudes fuel distrust in conventional medicine, which creates an obstacle in effective communication between the practitioner and patient (J. Borda M.D., personal communication, March 6, 2008).

> *Diarrhea is the number one killer in Bolivia and much of this statistic stems from the population's distrust in modern medicine. Patients would come into the consultation office daily worried because their child had severe diarrhea. The doctors would always tell them to make sure their child kept drinking plenty of liquids and would proceed to prescribe medication. However, the mothers were*

> *reluctant to do as the doctor had advised in giving liquid since it was coming out of the child as fast as it was going in, per say. Consequently, the mothers would stop giving liquids altogether and the child would die of dehydration.*

There are several explanations as to why a large portion of the population uses traditional medicine in Bolivia. Current rationale has been distrust in the present health care system and modern medicine, the cost of professional medical treatment and the impact of their family or cultural heritage. (Dente, J., Herman, C., et al) Furthermore, there seems to be distinct populations who adhere to the non-conventional treatment method. According to the Pan-American Health Organization, the healthcare services available to the Bolivian population are divided into three categories: formal (based on the "scientific method approach"), traditional (based on "culturally determined views of health"), and informal (essentially, "strategies for survival" or home remedies). Notably, 30% of the indigenous population adheres to the informal or home remedy category while 10-30% makes use of traditional medicine (Pan American Health Organization, 2007). The small amount of upper class citizens who do use some form of non-conventional medicine tend to use it as a supplement their formal health care, while the rural and poorer populations seem to heavily rely on various types of traditional healings as a substitute for conventional care. (Dente, J., Herman, C., et al) Hence, there seems to be a divide in usage and reasons for practicing traditional medicine in Bolivia which is greatly affected by ethnicity, as discussed in the previous section.

What can be done to improve the relationship?

In order to improve the doctor-patient relationship in regards to differing medical beliefs, a balance needs to be reached where both the physician and patient recognize and show consideration for the others' viewpoints. In Bolivia there have been programs

implemented to incorporate a more ethnomedical perspective in the healthcare field by combined methods of both the traditional and professional sectors of the pluralistic system.

One method of accomplishing this is to teaching traditional concepts of health and disease to modern medical practitioners, and then having them decide what aspects of the traditional method to change and which to leave alone. Furthermore, modern physicians could learn to use the Andean myths of the traditional system as a method to educate the disbelievers in modern medicine on how to truly cure disease (Bastien, 1987). The objective of these programs has been to educate medical personnel in the traditional beliefs and then to have them create joint strategies to improve the quality of healthcare. As a result, conventional and ethnomedical practitioners work together to teach the indigenous population the advantages of both types of medical practices, while helping them overcome their fears of modern medicine. Evidence for the effectiveness of this strategy has been the fact that the integrated clinics of La Paz have attracted more clients than the standard medical clinics (Bastein, 1994).

A similar method in combating this barrier has been the rising number of healers known as *"Los Naturistas."* Being of *mestizo* background and speaking both Spanish and Quechua, they are able to serve the indigenous and indian-mestizo populations as well as the upper-classes. These healers integrate explanatory models from both the traditional Andean medicine and modern medicine, but are selective in the sicknesses they treat. Although they predominantly use herbal medicines, as a group of healers, *Los Naturistas* are establishing a niche in the Bolivian health care system. By incorporating aspects of biomedicine and providing service to those groups who might not be able to access it

otherwise at a fraction of the cost, this option can improve health care significantly if used correctly (Bruun & Elverdam, 2006).

In view of this information, it seems possible that some aspects of traditional medicine can be tailored to fit into the modern medical sphere and is important for the cultural perceptions of health and socio-economic aspects of receiving care (Vandebroek et al, 2008). However, the unhelpful traditional and folk medical practices could be eradicated with an improved doctor-patient relationship with a conventional physician who is culturally competent and open to different belief systems, such as *Los Naturistas* seem to be.

Chapter Review

As we have seen throughout this chapter, a population's culture can strongly influence the formation of an effective doctor-patient relationship. Cultural dissimilarities that exist between the two parties such as ethnicity, language and medical beliefs can impinge on the professional relationship if not dealt with in the proper manner. In the United States methods for ending or reducing health disparities caused by cultural differences have been suggested based on research within multiple healthcare systems. According to the Agency for Healthcare Research and Quality (2003), healthcare systems should consider the following cultural competency techniques to narrow the gap between practitioner and patient as a result of cultural discrepancies:

- **Interpreter Services** – If healthcare facilities take an active approach to hire interpreters for both different languages and for

the speaking and hearing impaired, communication barriers can begin to decrease between doctor and patient.

- **Recruitment and Retention** – the healthcare system needs to be more conscious of the staff within their facilities. To reduce cultural disparities, more minority groups should be represented in the various healthcare offices and clinics.
- **Training** – it is important that healthcare professionals are trained to work in conjunction with interpreters, minority groups and people from diverse backgrounds.
- **Coordinating with Traditional Healers** – healthcare workers should be supportive and able to adjust healthcare plans according to the patient's cultural beliefs and traditional health practices.
- **Use of Community Health Workers** – individuals are needed to bring in sectors of the population who rarely seek out healthcare.
- **Culturally Competent Health Promotion** – information should be available via community health workshops or healthcare workers taking the necessary measures to promote early detection and treatment and outlining the good and risky health behaviors in relation to their culture and way of life.
- **Including Family and/or Community Members** – this particular cultural competency may be vital to obtaining consent and adherence to treatments.

(Agency for Health Research and Quality, 2003)

Thus, being able to identify the existence of cultural differences will prevent these issues from becoming obstacles to receiving the best health care possible. Furthermore, if at least some of these techniques that have been shown to narrow cultural effects in health care can be implemented in the Bolivian health system, I think the cultural barriers to the doctor-patient relationship would be much easier to overcome.

CHAPTER 5

Structural Barriers

Providing healthcare for a population affects almost every aspect of social and economic life of the country. Many of the barriers to this professional relationship in Bolivia stem from problems within the larger realm of infrastructure of the healthcare system, not necessarily the cultural differences between doctor and patient. Although all members of a community should have access to health promotion and direct medical services they need to optimize good health, much of the Bolivian population continues to face substantial barriers that limit its ability to form a lasting doctor-patient relationship. This is due to the shortage of primary care physicians, means of accessing healthcare services and the poor organization of the medical practice. This chapter will discuss these three mentioned barriers, how they affect the doctor-patient relationship and propose possible solutions to these obstacles. It is important to recognize that the structural barriers impeding the progress of an effective doctor-patient rapport are not detached from the cultural dilemmas facing the health care system. While this chapter will discuss structural barriers, take into consideration the previous chapter and how culture can play a pivotal role in the development and possible solutions to these dilemmas as well.

Shortage of Primary Health Care

The increasingly common trend in healthcare that can no longer be disregarded is the shortage of primary health care (PHC) physicians world-wide. As the planet's population continues to grow, the need for medical personnel becomes omnipresent to maintain the health of humanity. Unfortunately, the need for PHC physicians far outweighs the availability of such resources. The shortage of PHC professionals is the

result of two key factors: the decline as a result of the rapid proliferation of specialization and lack of human resources. This drift in medical practice in the United States is primarily due to the former, attributable to the rise in technological advancements and thus salaries of specialists in an increasingly progressive world. Only one in ten American physicians are in “general practice” (i.e., general or family practitioners, pediatricians and geriatricians), implementing a holistic approach to medicine (Pugno, PA., McGaha, AL., Schmittling, GT, et al). The National Residence Matching Program (NRMP), which is responsible for placing recently graduated medical students into their choice residency programs, is in accordance that the interest in family medicine and primary care careers in the U.S. has continued to decline over the past few years. “With the needs of the nation calling for the roles and services of family physicians, family medicine matched too few graduates through the NRMP to meet the nation’s needs for primary care physicians” (Pugno, PA., McGaha, AL., Schmittling, GT, et al). Regrettably, this healthcare trend is permeating the underdeveloped health care system in Bolivia as well. Specialization amongst Bolivian doctors is becoming ubiquitous due to the advantages similar to anywhere else in the world: increased salaries and more control of their career since they are more likely than PHC physicians to run a private practice (Uribe, personal interview, 03/2008).

As a result of patients seeing an increasing number of specialists in place of one general practitioner, the doctor-patient interactions become increasingly compartmentalized. It is arduous to build trustworthy and long-lasting bonds with four specialty doctors, rather than one primary caregiver that is familiar with the patient and his/her health record in its entirety, who can advise them to see a specialist if need be. A

parallel consequence of this trend is the quality of health care can suffer due to a specialist's tactic of focusing on one area of the patient's health and not the entire bodily system. Moreover, studies have shown that communicative behaviors as used by specialists are very "managerial" in style where there is no exploration of their patient's emotions, expectations or psychosocial aspects. This leads to decreased patient satisfaction with these encounters due to the doctor-centered style of a specialist which allows for little patient participation, and hence decreased satisfaction with the doctor-patient relationship (Ruiz-Moral, R, Perez Rodreguez, E, Perula de Torres, LA, & de la Torre, J, 2006).

The shortage of PHC providers in Bolivia due to the lack of human resources has led to the number of patients in comparison to the number of physicians at an all-time high. In 2001, there were 7.6 PHC physicians per 10,000 people as compared to the infamous U.S. shortage of 22.3 physicians per 10,000 people (Pan American Health Association, 2007). As a result of this physician shortage, Bolivian hospital clinics and emergency rooms with predominantly hospital-based physicians not trained to provide the important features of primary care, such as prevention and early management of health problems, become the "default" regular source of care (Bureau of Health Professions, 2005).

> *One week of my medical internship I was stationed with an Emergency Room pediatrician. Due to the lack of primary care physicians available in the public hospitals, many children were being seen by the E.R. doctors for reasons such as diahhrea, coughing and fevers; symptoms to American's that would seem nothing more than the average cold or flu. I was awestruck at how the E.R. doctors would treat the mothers bringing in their sick children; they were very condescending and dismissed the cases quite quickly. Although the children's symptoms might not have been E.R. worthy, they still had the right to be examined thoroughly and seen by a physician.*

Therefore, these problems of imbalance in the Bolivian healthcare setting persist as a consequence of specialization and also lack of human resources available. According to the Pan American Health Organization, the shortage of PHC providers in Bolivia is also indirectly caused by "an imbalance in types of training and low remuneration of medical and paramedical staff" (2007). Thus, it should be no surprise that with the statistics mentioned regarding the scarcity of PHC physicians in the Bolivian population, being able to develop a doctor-patient relationship is virtually impossible.

What can be done to improve the relationship?

In order improve the doctor-patient relationship there needs to be sufficient medical personal available to serve the population. If there is a shortage of physicians, then the development of a cooperative bond between doctor and patient cannot evolve. Hence, one approach to curb the decline in primary care physicians is to make the career choice more popular. As of now, multiple factors including student perspectives of career demands, rewards, lifestyle issues and the prestige of a specialty continue to influence medical students' career choices, while primary care is associated with an increased workload and meager pay in comparison (Pugno, PA., McGaha, AL., Schmittling, GT, et al). Therefore, since the demand is so high for PHC providers, the benefits and salaries of the career choice should reflect these needs. Also, organizing medical practices to decrease the demand and impact on physician lifestyle may support the upsurge of PHC physicians.

The dilemma of the deficiency of human resources in the Bolivian health care system could be based on numerous things such as funding for medical schools, the medical education system and, as mentioned above, the rewards of a career in medicine. Therefore, in order to shrink the gap between the number of doctors compared to patients, the country will have to make a career in medicine more appealing to students, while also finding means to fund increased training and the education of medical personnel. If this can be accomplished, it would increase the possibility of having an improved doctor-patient relationship between the two individuals because it would be more probable for a patient to visit a physician and the physician would be able to spend more of his/her time with each patient. The more time a doctor is able to spend with each patient has been shown to correlate with an enhanced relationship between the two involved parties, increased satisfaction with medical visits and ultimately improved health care outcomes (Ohtaki, 2002).

Access to Health Care Services

As if health care problems are not daunting enough, difficulty in accessing a clinic or hospital is another predominant factor which adds to the third-world country's mounting health care disparities. This dilemma is caused by numerous factors which are rooted in the country's extreme geographic diversity. The capital city of La Paz sits at 12,000 ft. above sea level, while two-thirds of the country is in the lowlands and another part lies within the Amazon basin. This challenging topography creates barriers to accessing medical care due to poor or limited transportation systems and inadequate health facilities in some sparsely populated regions (AHRQ). Furthermore, Bolivia's

geographic diversity means that physicians have to deal with a large array of diseases of the tropics, as well as those more common in high-altitude and temperate zones. Thus, throughout history Bolivia's health system has remained particularly unequal to the task of providing care to people in this challenging geography (Zulawski, 2007).

As a result of this diverse landscape, trained medical professionals are pathetically few in number in some regions compared to others. Hence, remote populations have to rely solely on local traditional healing practices, which can be inadequate or unsafe in critical situations. Unfortunately, formally trained medical doctors predominantly elect to stay in the capitals of departments (U.S. equivalent to a state) because they receive augmented governmental or private support for medical practice there than in the countryside. Consequently, there is an acute shortage of medical facilities and personnel in smaller towns and regions beyond the outskirts of the capitals. This leads to the more remote populations being less likely to have health insurance, they have more difficulty getting health care and have fewer choices in where to receive professional medical care (Zulawski). Unfortunately, the few care facilities available to the remote populations are usually inadequate and under funded. This leads to the inability to schedule appointments, excessive time spent in the waiting room, and limited operational hours of the clinics, which affect a person's ability and willingness to obtain needed care (AHRQ).

> *Every morning walking into the El Alto Clinica de Materna y Infantil (Mother and Infant's Clinic) I immediately encountered a line of women and children emerging from the clinic's entrance. The waiting room was always standing-room only, overflowing with patients waiting to be seen by the physicians and stray dogs sifting through garbage for anything to eat. Some of the indigenous women had traveled hours from home carrying their infants in a brightly-knit blanket swung over their shoulders in hopes to see a physician. Dr. Gutierrez, one of the pediatric physicians I shadowed, informed me that many of the patients would line up outside starting at 5am even though the clinic did not open until 8am to ensure*

> *that their children would be seen. Others who arrived at 8am ran the risk of sitting in the waiting room for 4 hours, only to be turned away in the afternoon because the doctors would limit their patients to around 30 each day. This allowed for no more than about a ten minute visit, unless special circumstances were required* (Gutierrez, personal communication, 02/2008).

These factors can have obvious implications on how well developed the doctor-patient relationship can become. If a person is unable to see a physician regularly or even not at all due to where they live in the country, a bond cannot form between the two parties. Furthermore, these remote populations may not seek medical attention when they need it the most because they do not have a local provider they trust to provide them with care. Besides being an evident doctor-patient barrier, limited access to health care services can lead to larger-scale health problems within the entire country if disease prevention and treatment are not available.

What can be done to improve the relationship?

Limited access to healthcare services is a huge structural barrier in the Bolivian health care system due to many reasons, such as; geography of the country, poor transportation, and the scarcity of physicians in some regions. In order to make progress in overcoming this barrier to the doctor-patient relationship, a reform of the entire healthcare system infrastructure is needed. According to the Pan American Health Organization (PAHO) (2004), Bolivia would benefit from "a policy framework that includes a commitment to universal access to health care and to strengthening the essential public health functions of the state." A program put in place throughout Latin America and the Caribbean known as the Millennium Development Goals is attempting to do just that. With an emphasis on equity, they have set certain goals to be reached by

2015 by all of Latin America and the Caribbean nations, with Bolivia in particular noted as being one of the poorest regions of this targeted area. The program has recognized that means to a better healthcare system that would provide access to all the people exist, but they are largely out of reach for the poorest and most vulnerable groups (PAHO, 2004). Thus, the millennium goals provide an opportunity for a concerted approach that recognizes health as a regional public good to be shared by all. Improvements that need to be considered include the locations of healthcare clinics, public transportation availability, expanded clinic hours, the physical environment of the clinic, and, of course, the rapport built with the patients by medical personnel (Ruiz-Moral, R. et al., 2006). These administrative, structural and organizational changes could provide a means for the Bolivian people to have greater access to health facilities and thus be able to establish a cooperative rapport with a physician.

Organization of the Medical Practice

With the shift in medical care from hospitals to outpatient clinics and physicians' offices in the past decades, there are increasing concerns regarding deterioration in the quality of medical care due to this structural change. The evolving trend of managed clinical care has the goal of refocusing systems and care management onto problems of a defined population rather than solely on the care of individual patients (Kongstvedt, 2001). Although this new organization of medical practice aims to provide care to better benefit the population, it can become a structural barrier when an individual patient’s well-being is overlooked. Likewise, the medical practice setting has been shown to affect a patient’s perception of the quality of care they receive (Reschovsky, Reed, Blumenthal,

& Landon, 2001). Hence, this shift in the organization of medical care can unveil hidden consequences.

As a result of these structural changes and shift to managed care, a side-effect that can go unnoticed is the fact that a doctor's previous autonomy has become submissive to the rules and regulations of major health management organizations (HMO). Consequently, physicians do not exhibit the same types of practice behaviors prevalent a decade ago; they are frequently forced to see more patients, spend less time per patient, are under more scrutiny to follow regulations of the HMO and are often paid less (Borda, personal communication 03/2008). Therefore, this infiltration of politics into the healthcare arena as a result of these changes in infrastructure can hamper the quality of the doctor-patient relationship.

An example of this effect on the professional relationship is that interpersonal communication between doctor's and their patients can be infrequent due to the decline in the doctors' ability to control their own practices owing to regulations put in place by HMO's. A survey completed by U.S. physicians even showed a negative association between the number of physicians that were under managed care contracts and the perceived quality of care they were able to provide their patients (Reschovsky et al., 2001). Unfortunately, this lower quality of care seems to be a result of this loss in autonomy; seeing more patients for shorter office visits may allow a larger proportion of the population to be helped, but quality of care can suffer.

> *Each day working in the El Alto clinic Dr. Guttierez was required to see between 20-30 patients over a period of 4 hours. This equated to about 7 patients an hour, where she could only spend about 8 minutes per visit.*

> *Under these circumstances, building a trusting and effective relationship with each of her patients was unattainable. A doctor I shadowed in the United States., Dr. Amy Card, had the same problem working in the Corvallis Clinic. She was scheduled to see six patients an hour for OB/GYN check-ups, which was hardly feasible, especially under special circumstances where the women had a lot of questions or a severe problem.*

Therefore, influences in all areas of the health care industry are affected by this shift in organization of the medical practice, and the doctor-patient relationship is not immune. Thus turbulence remains a prominent dynamic.

What can be done to improve the relationship?

In order for the doctor-patient bond to thrive in the new managed care setting, examination of the consequences, especially the unintentional consequences of such systems, must be thoroughly considered. Just as the patient-doctor partnership is pivotal in medicine, so too should be the interaction between doctors and the health care organizations. Ultimately, the delivery of high-quality care depends on both effective health teams and efficient health organizations. Every sector involved must focus on how the medical practice can be defined to better meet the needs of not only the population they serve, but individual patients concerns as well. One effective strategy might be to have teams of physicians and HMO workers who jointly work on these relevant issues, such as decline in time spent with each patient, and present operational solutions (Bender, 1995)

Thus, managed care should have maximizing value and quality as its main objectives, not just minimizing cost and providing care to mass amounts of people. Furthermore, it will be important to assimilate the regions cultural values and practices

into the managed care settings in order to provide the highest and most effective care possible. However, whatever the criticisms of managed care, the return to open-ended, fee-for-service medical care will not be successful nor tolerated by the public or private sector. Critical to the future of healthcare will be whether or not the government, health plans and physicians can reach a better understanding of each other's legitimate roles and objectives.

Chapter Review

In recent decades Bolivia, along with many other Latin American countries, has instituted broad reaching health reforms that in some cases have weakened public health systems, leading to the structural barriers discussed throughout this chapter. Moreover, we have seen how these obstacles can greatly affect the doctor-patient relationship and quality of health care received. Therefore, making up for these losses by investing in the health sector is crucial if the region is to make progress on meeting the specific Pan American Health Organization's millennium goals discussed previously. Although Bolivian president Evo Morales and other leaders have promised at successive Summits of the Americas and other world forums to increase investments in health, strengthening the region's commitment to the millennium goals remains a major challenge (PAHO, 2007). Making progress towards meeting these goals by the proposed year of 2015 in the Bolivian health care sector will require concerted action in three key areas: 1) The country must reduce disparities through targeted interventions; 2) increase investment in health and health systems; and 3) develop partnerships for health development.

The disparities that arise as a result of the shortage of physicians, limited access to health care services and changing organization of the health care practice and how they affect the doctor-patient relationship cannot be resolved by economic growth alone, but will require targeted interventions. This calls for policies and actions that aim towards providing health care to the rural poor in neglected regions of the country as well as marginal urban groups, such as unemployed youths and single-parent households. In addition, the region's health and social sectors must be able to operate efficiently together. Although in the past Bolivia has increased social spending as a percentage of GDP during the 1990s, these increases did not produce the expected results. Thus, the country must not only increase spending in the health sector and on specific programs, but also do a better job of assessing which mix of allocations produces the most cost-effective interventions and the greatest reductions in health care disparities (2007).

In conclusion, the Millennium Development Goals seem to be the current and most effective answer to coping with these structural barriers and ultimately how they affect the professional bond. Hopefully, they will get health on the agenda of economic and social development strategies and provide an opportunity to promote increased financing of health by giving new legitimacy and urgency to the need to invest in the Bolivian people.

CHAPTER 6

Conclusion

The relationship between a doctor and patient plays a central role in the quality and effectiveness of healthcare received, and it is apparent that cultural and structural barriers can have drastic affects on this bond. For the most part, an inefficient or unsuccessful relationship leads to hindered communication due to factors previously discussed, such as non-concordant languages, medical beliefs or merely poor access to healthcare services. It is apparent that finding solutions to overcome these barriers while being able to effectively communicate are necessary to build and maintain an effective doctor-patient connection.

Cultural differences – which are often associated with differences in languages and belief systems – constitute a significant barrier to effective communication. One's culture effects one's understanding of a word or sentence and even one's perception of the world. To simply learn a language is not the same as understanding a culture, because even those who share a common native language, such as Spanish in the Bolivian setting, may not share a common culture. And not everyone born in the same place and speaking the same language necessarily shares all the features of a common culture. Medical beliefs, for instance, can have a background rooted in the same language and town, but some might hold beliefs in traditional medicine while others prefer modern physicians. Therefore, there is a huge risk of either underestimating the effect of cultural differences or of stereotyping individuals by their culture. Both will interfere with the effectiveness

of communication which is absolutely neccesary to giving and receiving adequate healthcare (Fernandez, 2004).

Structural difficulties – which are often connected with the infrastructure of a particular medical system – are yet another huge avenue through which effective communication is bared. Yet, typically these obstacles are more easily prevailed over if the medical system had ample monetary and human resources at its disposal. Problems such as shortage of primary care physicians, access to healthcare services and a doctor's autonomy can all be adapted to fit the needs of the population to which they serve if enough of these resources could be obtained. Unfortunately, in poverty-stricken nations such as Bolivia, these shortages are much harder to resolve. The Millennium Development Goals, as discussed in Chapter 4, will hopefully provide a unique opportunity to promote increased financing of health, by giving new legitimacy and urgency to the need to invest in the Bolivian people. Lastly, it is important that the proposed solutions to these identified problems are adapted to individual medical systems, clinics and hospitals to have any positive repercussions.

Progression towards combating these health care barriers in Bolivia has been noticeably occurring in some areas of the health care system, but many medical facilities are still struggling to employ practices that reduce these cultural and structural effects on effective communication between doctor and patient. Furthermore, the system does not know necessarily which practices are most effective. And even when effective practices are known, their implementation of proper solutions in a reliable, sustainable, and efficient manner is challenging. Thus, more study and research in the area of doctor-

patient communication should be used to help provide some evidence-based solutions to this dispute specific to Bolivian healthcare statistics. The trick is going to be to recognize, however, that adaptation does not adequately represent the challenge of implementation. Too often, evidence-based practices are incorporated into the existing system, thereby adding higher expenses, increasing complexity and potentially compromising existing areas of the system that are working well (Fernandez, 2004). Instead, an evidence-based practice should be incorporated into a redesign of the system. For example, it would be more effective to incorporate more indigenous-speaking clinicians, starting at the educational level into the medical system, rather than to simply have a few nurses who can interpret the languages (Schyve, n.d.). Hence, by executing “band-aid” solutions onto the current Bolivian system and expecting it to integrate itself smoothly and efficiently will most likely end up being a waste of time, money and do nothing to improve the doctor-patient relationship in the long run.

Some of these cultural and structural healthcare goals may be easier to achieve than others, but to fulfill the overarching objective of reducing healthcare inequities by starting with the doctor-patient relationship, Bolivia must strive to reach beyond the minimum progression necessary for change and "raise the bar." This is undoubtedly a historic task that will require unprecedented political commitment, leadership, innovation and broadmindedness. It requires the Andean country to muster the necessary will and resources to ensure that health makes its proper contribution to cultural inequity reduction, governmental cohesion, and ultimately a better quality of life for the Bolivian people.

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APPENDIX

Las Preguntas para la Entrevista
(Interview Questions)

1. ¿Como las afectan los aspectos culturales a las relaciones entre el doctor y el paciente en Bolivia?
   (How do cultural aspects affect the relationship between the doctor and patient in Bolivia?)

   - Las differencias en etnicidades/raices de doctor y paciente (Por ejemplo, un doctor de raice espanola y un paciente indigena)
   (*The differences in ethnicity/race of doctor and patient? for example, a Spanish doctor and an indigenous patient)*

   - Las barreras de lenguas diferentes (Ej.: Un paciente que hable aymara o quechua) ¿Hay muchos doctores que hablen estos idiomas?
   (*The barriers of different languages For example, a patient that speaks Aymara or Quechua. Are there many doctors that speak these languages?)*

   - Las creencias en medicina tradicional y las costumbres tradicionales? ¿Como estos los afectan el tratamiento, la progression de enfermadedes, la relaciones del paciente y doctor?
   (The beliefs in traditional medicine and customs? How do these affect the treatment, progression of illnesses and the relationship between doctor and patient?)

   - ¿Que es el papel del doctor en la cultura de Bolivia? (un papel muy respetado)¿ Hay mucha confianza en el doctor? ¿El paciente tiene el opción para decidir sobre su tratamiento y salud o el doctor hace todas las decisiones?
   (*What is the role of the doctor in the Bolivian culture? Are they respected? Is there a lot of trust in the doctor? Does the patient have the option to make decisions about their treatment and health or does the doctor make all the decisions?)*

2. ¿Como las afectan los aspectos de la sociedad a las relaciones entre el doctor y el paciente en Bolivia?
(*How do aspects of society affect the relationship between the doctor and patient in Bolivia?)*

-¿el papel respetado está cambiando? ¿El dinero/titulo/poder profesional son factores importantes de la carerra? Si “Si”, como los afectan las relaciones? (Ej: En EEUU muchos doctores hacerlo para esas cosas.)
(*Is the respected role of the doctor changing? Is money/ degree/ professional power important factors of the career? If yes, howdo these factors affect the relationship? For example, in the U.S. many doctors choose the career for those benefits.)*

- ¿Piensa que doctores no siente compassion para los pacientes con enfermadades provenables? Como, VIH/SIDA que transmitio sexualmente o problemas con causas de decisiones malas?
(*Do you think that doctors have less compassion towards patients with preventable diseases such as AIDS/HIV that are sexually transmitted or problems as a result of bad decisions?*

- ¿Hay un problema en Bolivia con el numero de doctors primerias para el tamano de la poblacion? (overspecialization) ¿Como esto se afectan el tratamiento? ¿Las relaciones de los pacientes con los doctores?
(Is there a problema in Bolivia with the number of primary care doctors for the size of the population? How does this affect treatment and the relationship between patients and doctors?)

- ¿El doctor tiene menos autonomia que en el pasado? ¿Las organizaciones grandes, empresas de seguro o el gobierno tiene mas control de la medicine? ¿Como? Y si “Si” , como afecta la medicina?
(Does the doctor have less autonomy than in the past? Do the large organizations, insurance companies and/or the government have more control over healthcare? How? If yes, how does this affect care?)