Puerto Rican Health Beliefs and Practices: Exploring the Boundaries between Ethnomedicine and Biomedicine

by Lee M. Pachter

In a time when heterogeneity is becoming more obvious in communities, it is increasingly important for those in the health care professions to understand the cultural beliefs and practices of those in their care. Such sensitivity may at times require the practitioner to go against his or her strongly held biomedical beliefs and practices and acknowledge a belief system in which he or she may not believe.

As the population of the United States becomes increasingly diverse, the health care system is beginning to consider how it can best serve a patient population whose heterogeneity is more obvious than at anytime in the past. The terms "culturally sensitive" and "culturally competent" health care are cropping up in the medical literature frequently, and medical educators are discussing ways to teach students, residents, fellows, and practitioners how cultural values, attitudes, and practices affect health and health care provision.

The emergence of this new emphasis on ethnicity and culture is a welcome step, but if we oversimplify the topic we run the risk of actually increasing perceived differences between the dominant anglo "culture" and ethnocultural minorities. A discussion of the effects of culture on health and health care must acknowledge that these issues are as pertinent to members of the dominant culture as they are to minority groups.

What do we mean by the term *culture*? In its broadest interpretation, a cultural group is a collection of individuals who share common beliefs, attitudes, behaviors, lifestyles, and practices. Taken in this perspective, physicians and other health care personnel are members of a culture: the *culture of medicine.* If one accepts this view, then we can argue that every clinician-client interaction is in fact a cross-cultural interaction between the culture of medicine and the *culture of the patient,* regardless of the ethnicity of either the clinician or patient. This view puts the practice of culturally sensitive health care within the overall context of generally sensitive health care, and will guard against the ghettoization of cultural sensitivity as a special consideration that is only pertinent when dealing with "the other." However, as the cultural distance between patient and practitioner increases, the likelihood of discrepancies and miscommunication increases as well, and these cross-cultural issues take on an added importance.

In addition to differences between cultural groups, there is usually as much, if not more, diversity of beliefs and practice within a cultural group as there is between groups. The aim of culturally sensitive health care is not to stereotype, but to acknowledge specific beliefs, practices, and styles that are commonly noted within a cultural group. Any individual within that group may

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choose to conform to these beliefs, practices, and styles in varying degrees and in varying situations.

Given these caveats against stereotyping within a culture, I will discuss how ethnomedical (or folk) beliefs affect health and health care issues in mainland Puerto Rican communities. Ethnomedical belief and practice is but one area in which cultural influences affect health care, but it is an area that serves as a good example of the ethical issues that a clinician may face when working in the multicultural environment. The health care practitioner must sometimes go against his or her strongly held biomedical beliefs and practices and acknowledge a belief system that he or she may not believe in. This flexibility is crucial if one is to provide health care services in which patients trust and with which they feel comfortable.

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The Puerto Rican culture has a rich tradition of folk remedies for many ailments. Sometimes these beliefs and practices fit within the biomedical system; at other times the concordance between biomedicine and ethnomedicine is more tenuous. The fact remains that some individuals will act upon these beliefs, often in parallel with biomedical therapy. I believe that the clinician needs to be aware that these beliefs and practices exist, and attempt to forge a bridge between the two systems whenever possible. I will illustrate this by presenting case studies of how health care practitioners have attempted to mediate between the two systems, and point out the ethical issues that may arise. Before presenting the case studies, I will give a brief overview of the traditional Puerto Rican ethnomedical belief system. This will illustrate that the practices described in the cases are not idiosyncratic behaviors but, in fact, manifestations of a consistent, internally logical, and coherent belief system regarding the maintenance of health and the treatment of illness.

Traditional Puerto Rican Ethnomedical Beliefs

Much has been written about health beliefs and practices in the Puerto Rican community (Harwood 1981). Common themes in the literature include the importance of balance and equilibrium, emotions as a cause of illness, and spiritual/religious causes of illness.

Balance and Harmony

According to traditional beliefs, health is a state of balance, harmony, and equilibrium; illness occurs when this balance is upset. The concept of balance/imbalance as it pertains to health and illness can occur in different spheres: the internal body, psychological, social, and spiritual. An imbalance or disequilibrium in any of these spheres can cause "dis-ease" or illness.

Perhaps the most commonly described example of this concept is the humoral, or hot-cold theory of illness (Harwood 1971). According to this belief, health is defined as a balance between hot and cold aspects. Illness is a deviation from this balance; there are hot illnesses and cold illnesses. Treatment for hot illness includes remedies and foods that are cool or cold; likewise treatment for cold illnesses includes administering warm remedies or foods to restore the humoral balance ("hot" and "cold" do not necessarily refer to temperature, but can be innate qualities of remedies or foods). Humoral theories are pan-cultural and can be found in many areas of the world.

Emotions as a Cause of Illness

Linked to the concept of balance, traditional Puerto Rican beliefs include the importance of maintaining a balanced mental state as a way of staying healthy, and that uncontrolled emotions

can be a cause of distress and illness. Physical as well as emotional illness may result from overwrought emotions. Common idioms of distress in the Puerto Rican culture exemplify this concept; "nerves," *ataque de nervios* (a culture bound syndrome commonly identified in Puerto Rican communities), stress, high blood pressure, and asthma are all thought by many traditional Puerto Ricans to have some relationship to emotions.

Religious and Spiritual Causes of Illness

Spiritism is a belief system frequently described when discussing traditional Puerto Rican culture. Although probably a minority of individuals in most communities consider themselves members of spiritist groups, many other people subscribe to certain parts of the spiritist ideology.

Spiritism includes the belief that spirits and saints can have an effect on a person's life. Illness can be caused by a number of reasons according to spiritist beliefs. Physical causes may include common biomedical beliefs such as viruses and infection, as well as physical causes that are not part of the biomedical system, such as humoral imbalance or belief in qualities of the blood such as weakness or thickness. Another cause of illness may be a disturbance in the spiritual realm, between a person and either his guardian saint or a spirit of a deceased individual. A third cause of illness is social disharmony. For example, malevolent feelings that a person may harbor against another individual may be thought to cause illness.

These concepts are central aspects of traditional Puerto Rican ethnomedical beliefs. Again, one must remember that these beliefs and the resultant practices are not engaged in by *all* Puerto Ricans. They are commonly described ideas that some individuals may act upon in certain situations. The following are specific clinical situations in which some of these beliefs and practices and the clinician's response to them may have had an effect on the health care encounter. In each case different ethical issues are presented for the clinician, issues which do not have "right" or "wrong" answers, but which need to be evaluated within the context of providing care which is sensitive to the needs and beliefs of the client.

Case 1: A mother presents to the office with her three-year-old son, who has been diagnosed with asthma. A bronchodilator syrup had been prescribed at the last office visit to be taken at the onset of symptoms. The child has been sick for two days with cough and wheeze. The clinician is able to stop the symptoms with a nebulized treatment of bronchodilators, and upon further discussion with the mother, she discovers that the mother has not been giving the child the prescribed medication because she thought that the frequent medication might cause a weakness in the blood. Instead, she has been giving the child a remedy that was recommended to her at a *botanica* (a shop in many Puerto Rican communities which sells folk remedies and religious articles). The remedy is a mixture of cod liver oil, aloe vera juice, *agua maravilla* (witch hazel), honey, and egg white.

Case Comment: The clinician has to deal with three related issues: nonadherence to prescribed medication, a health belief that is not recognized within the biomedical paradigm (too much medicine will weaken the blood), and the use of a remedy that also is not recognized in biomedicine.

Asthma is a common illness in the Puerto Rican community; therefore, it is not surprising that a strong belief system exists regarding asthma, one which combines ethnomedical and biomedical concepts. Treatments often consist of a combination of clinician-prescribed medications and folk remedies which include herbal teas and syrups, camphor rubs, and massage. None of these treatments are considered harmful if used either as directed on labels or as prepared in the standard fashion. Therefore, the clinician needs to find out the specific ways in which this family is using the remedies to assure that the potential for adverse effects is minimal.

Once this has been accomplished, the following issues remain: How can one increase the adherence with the biomedical treatment plan while

still acknowledging the mother's (as decision maker) autonomy and respecting her beliefs? Should one advocate the use of a remedy that has no effectiveness for asthma according to the biomedical paradigm? One answer lies in the combination of folk and biomedicine. By "hooking" the biomedical therapy onto a nonharmful practice that is accepted by the individual, adherence may be increased. The clinician may say, "I'm not sure if the remedy that you are taking is helping your child's asthma, but I know it is not harmful, and if you want to continue to use it, that's your decision. I'm certain, however, that it will work better if right after giving your child the remedy you follow it with a teaspoon of the medicine that I prescribe." By working within the patient's belief system, the clinician acknowledges and respects these beliefs (while not necessarily agreeing with them) and sets the stage for better "compliance" or "adherence" with the medical therapy by fitting it within the patient's cultural lifestyle. In this way, the ethical issue regarding condoning a noneffective remedy becomes a non-issue: the folk remedy *is* effective because it is being used to increase adherence with the biomedical therapy.

The mother's concern about the prescribed medication causing the blood to weaken needs to be addressed through patient health education. If concerns still exist after a discussion about the medication, the clinician may then recommend that instead of not taking the medication, the mother may want to give the child a vitamin or "tonic" (commonly bought in *botanicas*) to guard against weakening of the blood. Again, these remedies are not usually harmful and their use may help the patient to more consistently take the prescribed medication and thus more effectively control the illness.

> *Case 2:* A six-week-old child was admitted to the pediatric inpatient unit of a hospital with a history of fever, irritability, and decreased appetite. The plan for hospitalization included a diagnostic work-up for neonatal sepsis and the institution of antibiotics while culture results were pending. On admission, a bracelet made of red and black stone beads was noted on the child's wrist. The nurse removed the bracelet from the infant's wrist, to the obvious consternation of the infant's grandmother, who objected to the removal of the bracelet. The nurse explained that a bracelet on a child this age was not safe, and refused to place it back on the child.

Case Comments: A knowledge of traditional Puerto Rican ethnomedical beliefs would have explained why the grandmother was so concerned when the bracelet was removed from the child. The bracelet is more than just a cosmetic piece of jewelry; it is an amulet to protect the infant from *mal de ojo*—evil eye. In many Latino cultures, the belief in *mal de ojo* is common, and is thought to be an illness caused by envy. Infants and children are particularly susceptible to *mal de ojo* due to their relative purity, as well as their helplessness. A malevolent adult who secretly covets a child and who may be envious of the parents can place a spell on the child. This usually occurs when the adult expresses praise for the child, for example, by saying things such as "What a lovely baby," "How pretty," etc. A child under the spell of *mal de ojo* may display symptoms such as lethargy, irritability, lack of appetite, or failure to thrive. Prevention *of mal de ojo* includes wearing the stone-beaded bracelet; treatment for the malady includes going to a spiritist *(espiritista* or *santera)* for cure.

Given this information, the grandmother's concern is understandable. Since the infant had symptoms of illness, concerns for *mal de ojo* may have been present and the removal of the bracelet may have been interpreted as increasing the susceptibility of the child to get sick. In this case there is a discrepancy between the patient or family's beliefs and those of biomedicine. Should the clinician condone health beliefs and practices that do not fit into the biomedical system?

Allowing the bracelet to remain on the infant does not conflict with the dictum of medical care, "First, do no harm." (Those concerned that a bracelet on a young infant may cause abrasions

or potential strangulation may recommend that it be safety-pinned to the child's underclothes.) Moreover, although the practice itself may not be medically beneficial to the medical care of the patient, it may ultimately create a therapeutic alliance between clinician and client, thereby benefiting the patient's care and welfare. The acceptance of the family's beliefs and practices creates a therapeutic environment wherein the family feels that the system is respectful and responsive to their needs and will feel more comfortable using the system when appropriate and necessary.

> *Case 3:* A mother brings her fifteen-month-old daughter to the pediatrician's office with vomiting, decreased appetite, diarrhea, and low-grade fever. The physical exam shows a well-hydrated child with no evidence of gastrointestinal obstruction. The biomedical diagnosis appears to be a mild, self-limiting gastroenteritis, but in private the nurse tells the physician that the mother thinks the child has an illness called *empacho* and that she came to the doctor only to make sure that it wasn't anything else. The mother is now planning to take the child to a traditional folk healer who treats *empacho.*

Case Comment: This case illustrates the fact that although the ethnomedical and biomedical sectors of the health care system are separate, individuals often use both systems in parallel. It has been estimated that up to eighty percent of sickness episodes are treated outside the doctor's office (usually at home), and of the episodes that do make it to the doctor's office, a significant proportion of them turn out to be self-limiting illnesses that require minimal, if any, medical intervention (Kleinman, Eisenberg, and Good 1978). This appears to be the case with this child.

The mother believes the child to have a folk illness called *empacho,* thought to be caused by some dietary indiscretion—mixing certain foods, eating at the wrong time, eating spoiled foods, or in the case of infants, mixing different types of infant formulas or swallowing saliva during teething. What is thought to occur inside the body is that the food gets "stuck" to the walls of the stomach or intestines, causing bloating, vomiting, stomachache, and diarrhea or constipation. Treatment includes altering the diet, ingesting herbal teas and mild purgatives or laxatives, and going to a traditional healer called a *santiguadora* to have a special massage which "dislodges" the food from the walls of the stomach (Pachter, Bernstein, and Osorio 1992).

The question arises: If *empacho* is a self-limited illness that require no medical intervention, and if there are healers within the community who are known to treat the symptoms, why do health care practitioners need to know about this particular folk illness? As our case illustrates, individuals do enter the biomedical care arena even when they think that their illness episode is *empacho.* Parallel utilization makes sense when one appreciates that 1) the diagnosis of *empacho* is usually made after a biomedical diagnosis has been ruled out, 2) parents may be thought of as neglectful if they do not take their children to the doctor when they are ill, regardless of the "cause" of the illness, and 3) even the folk healers recommend that the parents bring the child to the doctor, and if after that the child is not better (or the doctor says there's "nothing wrong" with the child) they should then return to the healer.

The physician in the case study has to decide whether to ignore the parent's concerns about *empacho* and only attend to the medical diagnosis and treatment, or question the parent about her beliefs and her plans for therapy. I recommend discussing the mother's concerns with her. I would also inquire about what she is hoping to get out of the visit to the doctor and find out what her plans are once she leaves the office.

In this case, the mother did explain her beliefs about *empacho* to the physician and told him that she came to his office "just to make sure there was nothing wrong that the doctor needed to treat." Once she was assured of that, she planned to seek the assistance of a *santiguadora* who was planning to massage the child and prescribe some teas.

With this knowledge, the doctor did a thorough

exam of the child after which he told the mother that there was nothing that he felt needed to be treated with medicine. He also gave his OK to the mother to seek treatment from the *santiguadora,* but requested that she call him before she administer any tea or laxative so that he could determine whether the remedy was safe for a child. The mother was relieved that the child did not have any serious medical condition, and complied with the doctor's wishes, phoning him later that day. The child was in her normal state of health within a few days.

Each health care practitioner needs to determine how far he or she feels comfortable in merging ethnomedicine and biomedicine. At the least, he or she should be able to discuss these issues with patients and objectively obtain information without making the patient feel "stupid" for believing in concepts that have no basis in the biomedical paradigm. Some clinicians may feel comfortable going only this far; others try to find innovative ways of bridging the gap between folk and biomedicine. This case provides one example of how it can be done.

We have on occasion gone further and actually invited santiguadoras to come to the hospital to assist in treating hospitalized children whose parents thought that part of their illness was due to *empacho.* The children—one with dehydration and gastroenteritis, another with weight loss (failure to thrive)—were being treated in standard medical fashion, and the addition of the santi*guadoras'* treatments did not interfere with the medical management. Both children were discharged from the hospital with follow-up visits scheduled with both the physician and the folk healer. By allowing the families to express and act upon their strongly held beliefs, we created a stronger bond between them and the health care system, and I believe that these families will not be hesitant to seek medical care in the future. Again, the argument of "ultimate benefit" can be applied when considering if we as health care practitioners should condone folk illness beliefs and nonconventional therapies.

An alternative approach is to challenge the client's nonbiomedical beliefs and attempt to alter behavior so that only medically sanctioned practices are undertaken by the client. I would argue against this approach. It is unlikely that a clinician can substantially alter long-standing beliefs and values in a brief clinical visit. Moreover, it is not the clinician's responsibility to act as a "biomedical missionary." The goal of the health care system is not to create converts to the biomedical paradigm, but to work collaboratively with the patient and act as an agent to assure the health and well-being of the individual. In this regard, the clinician should utilize any and all tools available, biomedical and otherwise.

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Some clinicians may argue that the acknowledgment and utilization of "nonscientific" beliefs and practices may be contrary to the objective, scientific tenants of biomedicine. However, if taken in perspective, not all of medicine is objective or scientific. For example, if a biomedical practitioner was presented with an illness that "has no standardized diagnostic criteria, that consists primarily of subjective symptoms, and that resolves in a relatively brief period..." he or she may question the utility of such an illness classification. The description may have been used for a folk illness such as *empacho,* but in fact it is a description of the biomedical illness called colic.

These case studies are presented to illustrate how ethnocultural beliefs and practices may have important implications for the provision of health

care to members of the Puerto Rican community. I have limited the discussion to issues regarding ethnomedical beliefs and practices, but one could also discuss other related issues such as cultural and linguistic differences that affect the clinician-client communication, roles of family members and individuals in medical decision making, and the effects of poverty on health care decisions.

With regard to ethnomedical beliefs and practices, the culturally sensitive physician should

- become aware of the commonly held ethno medical beliefs and practices within the com munity he or she serves
- assess the likelihood that a specific patient subscribes to those beliefs, and to what extent and under what circumstances
- attempt to find innovative ways to negotiate between biomedical and ethnomedical belief systems (Pachter 1994).

Doing this does not require that the clinician necessarily accept the beliefs and practices as "correct" or "truthful." Rather, it requires an acceptance of the diversity, and a commitment to broaden the boundaries of clinical care and incorporate into it some of the diverse beliefs and practices in order to make the health care system more concordant with the client. One may assume that better health care outcomes such as satisfaction with care and better adherence to therapeutic suggestion may result.

References

Harwood, A. 1981. "Puerto Ricans."In *Ethnicity and Medical Care,* edited by A. Harwood. Cambridge, Mass: Harvard University Press.

———1971. "The Hot-Cold Theory of Disease: Implications for the Treatment of Puerto Rican Patients." *JAMA* 216 (7): 1153-1158.

Kleinman, A, L. Eisenberg, and B. Good. 1978. "Culture, Illness, and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research." *Annals of Internal Medicine* 88:251-258.

Pachter, L.M., B.O Bernstein, and A. Osorio. 1992. "Clinical Implications of a Folk Illness: *Empacho* in Mainland Puerto Ricans." *Medical Anthropology* 13:285-299.

Pachter, L.M. 1994. "Culture and Clinical Care: Folk Illness Beliefs and Their Implications for Health Care Delivery." *JAMA* 271 (9):690-694.

Additional Readings

Hughes, D.M. 1987. "When Cultural Rights Conflict with the 'Best Interests of the Child': A View from Inside the Child Welfare System." In *Child Survival,* edited by N. Scheper-Hughes. Dordrecht: D. Reidel: 377-382.

Klessig, J. 1992. "The Effect of Values and Culture on Life-Support Decisions." *Western Journal of Medicine* 157 (3):316-322.

Mull, JD. 1993. "Cross-Cultural Communication in the Physician's Office." *Western Journal of Medicine* 15 (9): 609-613.