

# Asian Patients' Distrust of Western Medical Care:

## One Perspective

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### Abstract

Asian patients receive, with significant frequency, suboptimal medical care. The sources of shortcomings in the treatment of the Asian American patient are examined in this paper. I argue that it is mainly a failure to interpret patient behavior correctly which causes suboptimal treatment. Such failure stems not from prejudice, but from a lack of understanding of, much less respect for, the systems of thought about health and illness which form the basis for the traditional or tradition-influenced Asian American patient's approach to illness. "Noncompliant" patient behavior is misunderstood if the physician does not grasp the roots of such behavior in a system of beliefs which is not his own. Misunderstanding begets further "noncompliance," initiating a downward spiral. The way out of such spirals lies, I argue, in seeking a more adequate understanding of the patient's beliefs and their behavioral consequences.

**Key Words:** Medical philosophy, Asian Americans, distrust, communication skills, medical ethics.

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IN RECENT YEARS, the demands of medical practice in a managed care setting have placed increasing pressure on physicians to gain greater yields from less time spent in consultation with each patient. At the same time, the patient population is becoming ever more ethnically diverse, with increases in not only the absolute number of minority patients, but also in the variety of cultures and languages to be encountered. In New York City, the most significant cultural influxes are Hispanic, Asian, and Slavic. Indeed, the Asian immigrant population is itself composed of a myriad of subgroups and cultures, all of which are quite different and incomprehensible even to one another. The Latin population also has a variety of distinct cultural traits, although its subgroups may be less extremely divided than the Asian populations. Suffice it to say that American physicians today confront a multivariied patient population.

This rapidly changing demographic situation compounds the physician's difficulties in provid-

ing quality care. The constraints of time and finances are well discussed elsewhere. The limitations placed on the physician's effectiveness because of minority patients' inherent distrust of Occidental medical philosophy, however, are rarely addressed or acknowledged. This often subconscious barrier to full trust between the physician and the patient has dramatic effects on the effectiveness of our health care delivery, particularly in terms of patient compliance. Asian immigrants, in particular, have great difficulties with Western physicians. Their situation merits close examination, both because of the differences between the bases of their distrust and the distrust of other racial groups, and because of the general utility of determining the appropriate physician response to the kinds of distrust which different Asian patient groups exhibit. I will first address what I believe to be the main reasons why Asian patients distrust European medicine, then suggest methods by which physicians can counter their Asian patients' reluctance to believe in our abilities.

Asian immigrants usually come from cultures with long traditions of herbalist or shamanistic healing. The major cultures of Asia, and the

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Chinese in particular, believe in a concept of health based on the flow of energies within the body. The particulars of these beliefs are not necessarily important for this discussion. What is vital in contributing to the Asian patient's distrust of Western medicine is the degree to which this philosophy pervades all aspects of daily life. In most Asian cultures social behavior tends to be centered on the drinking of tea; all medicines are essentially brewed from herbs, which can be appropriately seen as teas for treating specific ailments. To this day, nowhere in the world, except in Asia, do "energy" beverages dominate the soft drink market. The maternal role in promoting daily well-being is particularly focused on the provision of proper nutrients, usually in the form of soups, to cure ailments or simply to promote quotidian wellness. Tiger, rhinoceros, and other animal-based extracts and essences are still in high demand for the same reason. Traditional philosophies upon which Asian concepts of health are based pervade daily life; they are not reserved only for times of sickness. Thus, it is easy to appreciate the feeling on the part of Asian patients that any philosophy of medical practice which is not based in the firmament of energy-flow concepts, is not to be trusted. It is very difficult for Asian patients in general, regardless of social position or education, simply to cast aside large tracts of their cultural heritage in favor of Western scientific concepts, particularly during the vulnerable times of illness.

Asian patients' distrust of the unfamiliar Western health model manifests itself primarily through noncompliance, which can span the continuum from half-hearted medication compliance to total refusal to consult Western doctors. The underlying lack of faith is often expressed as cultural or racial chauvinism. Patients have expressed to me their willingness to receive my advice because I am Asian. They say, "The foreigners don't really know how to treat our illnesses," or, "They don't really know what our illnesses are like." This occurs despite the fact that I have merely repeated exactly what the attending physician just said in English, and where a language barrier was not at issue. These patients believe that disease processes somehow manifest themselves differently in Asians, and that no matter how experienced Westerners may be, they do not comprehend the nature of Asian illness and, therefore, could not possibly treat Asians effectively. Asian patients do not readily accept the inherent universality of Western medical science.

There is, however, a more emotional patient stance behind this rejection of Western medicine.

Asian patients sense that when Western physicians ignore Asian health concepts, they are not only dismissing the traditional Asian concepts of illness, but also dismissing all of the patient's beliefs. Asian patients often suspect that some alchemical mixture of race and culture is the motivating factor behind Western physicians' dismissal of their beliefs. They fear that attitudes of cultural superiority and biological difference lurk beneath the surface. This underlying racial tension disguises itself as the patients' belief that different theories of illness are actually reflected in different disease mechanisms. The verbal expression of that racial tension as cultural superiority by Asian patients only leads to further frustration on the part of the physician. The readiness of many physicians to dismiss traditional Asian concepts of health only fuels this flame. Once the Asian patient rejects the applicability of Western medicine to his condition, compliance with physician recommendations becomes improbable. With a strong tradition to fall back on, the Asian patient may not feel that he is at any disadvantage in terms of receiving proper health care when he instead turns to alternative therapies of questionable value. It is left to the physician to wonder exactly why his efforts to provide care for the Asian patient are inadequate.

An exacerbating factor in Asian patients' often dissatisfying experiences with Western health care is a problem common to all immigrant populations: the language barrier. The inability of the physician and the patient to communicate properly often serves to reinforce the feeling on the patient's part that the physician does not really have any understanding of the illness afflicting the patient. The Asian patient becomes reticent, and often is embarrassed by the inability to communicate. My colleagues have interpreted the patient's silence as open hostility. They are, after all, accustomed to the normal banter between a professional and her patient. It is extremely difficult for the physician to sympathetically care for a patient in this context of silence. This scenario necessarily has negative implications for the quality of care and the patient's willingness to accept care.

The language barrier that magnifies the Asian patient's culturally based distrust of Western medicine is not solely the patient's fault. The physician who encounters a patient with whom he will have language difficulties cannot help but begin to feel less certain of the patient's history and physical examination. Often the physician will begin to simplify his speech in order to glean what he considers to be vital information. This is

not necessarily a bad response to an uncertain situation; I myself have done the same thing when encountering Spanish-speaking patients. The simplification of communication, however, has specific implications in the treatment of the Asian patient. If the Asian patient distrusts Western medicine because it does not accord with his accustomed view of disease processes, then the physician's simplification of communication will only further alienate the Asian patient. The lack of an adequate explanation of the Western physician's rationale for treatment tends to reinforce the Asian patient's distrust. Without it, he lacks a clear rationale for treatment and has no reason to give the Western physician any credence, much less a reason to abandon his more familiar traditional notions of illness and health. The physician who is uncomfortable with the Asian patient and does not accord him an explanation reinforces the Asian patient's belief that the Westerner does not understand his illness.

At first glance, it seems that there is little that the private physician can do to counter the long legacy of culture and history. Actually, the methods that one can use to overcome the inherent distrust of some Asian patients are quite simple. We must keep in mind that many patients may not distrust Western physicians at all. For those who do, much of the distrust is present only upon initial encounters with a Western physician, and for the vast majority of these patients feelings of mistrust arise only in response to a perceived slight. The physician who is cognizant of the possibility of causing offense has many weapons in his arsenal with which to preempt misunderstanding and distrust.

The first point is to communicate acceptance of the Asian patient's traditional beliefs. The physician does not have to change everything the patient believes about health and illness; he just has to convince her that she should trust the physician enough to follow his advice. I have found it very useful to tell the patient that herbal medications work for some people, but not all patients, while the treatment I recommend has been shown to be the most effective in most people. So long as the patient understands that the physician is sincere and respectful, he will usually abandon his distrustful attitude.

The second point to keep in mind when dealing with a potentially distrustful Asian patient is to explain one's rationale. The great exacerbating element in distrust is ignorance. If the physician takes the time to explain the rationale for treatment, giving a traditionally minded Asian patient

a reason to accept treatment, the patient will usually trust the physician. If given a good reason, most Asian patients will gladly follow the advice of the physician to the letter. Often, I have found that Asian patients will not understand exactly what I have said, but that my sincere effort to give an explanation will sway their decision away from traditional remedies and toward adherence with Western medical regimens.

Lastly, certain characteristics of Asian society lend themselves to overcoming any lingering distrust. Such small gestures as a simple greeting in the patients' native language, or the effort to pronounce the patient's name correctly, will often endear the physician to the patient and demonstrate the physician's respect for his person and his culture. Understanding kinship relationships at the core of Asian societies may also be worthwhile for physicians treating significant Asian populations. The physician's ability to function within those hierarchies will make the patient's attitude less adversarial. The whole point is to avoid the problem of the patient thinking of the physician as a threatening "foreigner" and to encourage the patient to view the physician as someone who is trustworthy and who will try to understand their native culture. This may be difficult for those with no experience with traditional Asian social structures or who only occasionally encounter Asian patients. Nevertheless, awareness of the nature of kinship relations allows the physician to recruit assistance from family and even friends of the particularly guarded Asian patient. If the physician can explain the necessity of compliance to an English-speaking close friend of a suspicious patient, she can be fairly certain of having a powerful advocate for compliance.

These statements are, of course, broad generalizations based on anecdotes and experiences, through the limited lens of one person's work with Asian patients and family members. I do believe, however, that they provide a useful framework for improving interaction with Asian patients. The fortunate fact is that Asian patients, though capable of suspicion, will usually accept care, and comply carefully with medical advice if given reasons to do so. In this sense, they are like most other patients. Asian patients are, in fact, more trusting than many African American patients, who unfortunately have historical justifications of their distrust of the medical profession. With an awareness of potential pitfalls, the physician can easily avoid the distrust of the Asian patient.