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Living within the Biomedical Paradigm

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I. Introduction: Giving shape to the Biomedical Paradigm

The Biomedical paradigm, like other perceptions of health and illness, is characterized by distinct attributes that are culturally determined. Arthur Kleinman (1978,1988) is one of the premiere scholars on the field. In his writing, he clearly ILLUSTRATES THE FUNDAMENTAL PATTERNS UNDERLYING THE WESTERN UNDERSTANDING OF HEALTH AND ILLNESS.

Kleinman writes that a pillar of the Biomedical paradigm is the division between the mind and body. The body is thought of as a machine, whose functioning is completely unrelated to the mind---i.e thoughts and emotions. Although this separation seems natural and universal to those who exist within the Biomedical paradigm, the division is both recent and unusual. Many cultures experience the mind and body as one holistic system.

The tendency to divide interconnected experiences can be seen in the dichotomy between illness and disease. Illness is the lived experience of sickness, while disease is "abnormalities in the structure and function of body organ and system" (Kleinman et al. 1978:252). A patient goes to the doctor's because of the experience of illness. A plumber can no longer bend over because of back pain, a student cannot study because of reoccurring migraines. Kleinman (1988:3) writes, "Illness refers to how the sick person and the members of the family or wider social network perceive, live with, and respond to symptoms and disabilities".

Problems of illness are what promote patients to seek professional help. They come to the doctors to treat symptoms and the subsequent problems caused by the symptoms of their disorder.

In the exchange between patient and doctors, the medical practitioner translates the patients'

experience of sickness into "signs" or symptoms of the underlying disorder (Kleinman.1988:17). The doctor is trained to treat the disease, the abnormalities in the body's functions, not the illness (Kleinman. 1978l: 252). Doctors focus on curing the disease while patients focus on treating the illness (Kleinman et al. 1978: 252). As a result, the doctor-patient interaction may become an interrogation. The patient's descriptions of illness may be thought of as distracting from the true cause of the sickness; therefore doctors often view the patient's illness narrative with suspicion (Kleinman. 1988: 17).

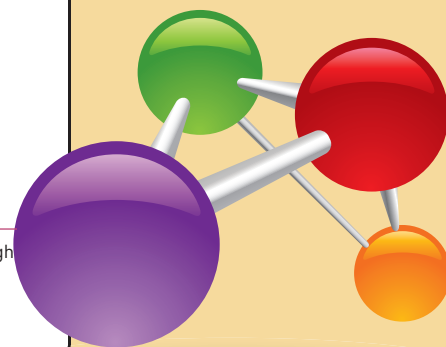
This separation of illness and disease is by no means natural or universal. In fact, other forms of traditional medicine treat, not just the disease, but issues of illness faced by the patient, including working with and consulting the family (Kleinman et al. 1978: 252). In the Western approach diseases that are based on detectable biological causes are considered more legitimate then those that are not. Other psychological aspects of illness are seen as secondary and messy. As Kleinman writes, "The Biomedical view of clinical reality, held by modern health professional in developing as well as developed countries, assumes that biologic concerns are more basic, "real", clinically significant, and interesting than psychological and sociocultural issues" (Kleinman. 1988: 25).

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* Thank you to my friends and family for guiding me through this stressful time. Thank you to my professor Aurora Donezelli for a wonderful class and for helping me give shape to my paper. Thank you to all who allowed me to interview them and to Arthur Kleinman and Roland Littlewood who's writing is the foundation of my paper.

¹ The use of the term "Western" is problematic as it implies a strict division between the "West" and the "other". The term "West" in this paper refers to paradigms that originate in the Europe and the United States, but are not necessarily exclusive to those areas.

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Kleinman (1988: 76) makes the point that the focus on treatment of the physical disorder, leaves little room for the experience of illness to be discussed and dealt with. A woman with a broken arm may leave the doctors with her bones set and a cast on, but "the patient's fear, the family's frustration, the job conflict, (...) and the financial crisis" that go along with the broken bone are left unaddressed (Kleinman: 1988: 6). Patients are expected to deal with the emotional, social and spiritual unrest that arises with illness either by themselves or through other resources such as a church, a support group, friends and family. The disregard of the personal experience of illness is the loss of a potentially productive avenue of treatment. A physical disorder does not exist in a vacuum, with the disease comes a change in one's reality that must be addressed.

While the Kleinman portrayal of the Biomedical paradigm is largely based in truth, it does not necessarily account for the variations and intricacies involved in such a social exchange. Whenever a paradigm or social phenomenon is described and labeled there is a serious danger of essentializing the experience. The body and mind are always thought of as separate, doctors never treat issues of illness and disease is always addressed first. The problem with this portrayal of the medical system is that it is too static. The Biomedical paradigm is portrayed as a monolithic entity that does not take into account personal variation and fluctuation.

2. Ethnographic Work: Patients

My ethnographic work on the subject of the Biomedical paradigm collaborates Kleinman's portrayal of the subject. However there are cultural and personal variations left unaccounted for. In my ethnographic work I interviewed four people. Three of the sources retold their personal narratives of illness and one was a doctor who spoke about working within the Biomedical paradigm. All shared similarities with Kleinman's description of the medical field, especially concerning the patient's personal experience of illness.

The two-illness narratives focused on are Alice's and Melissa. Both Alice and Melissa are sophomores at Sarah Lawrence College. Alice, who is originally from Northern California, describes a hospital stay in the United States after getting ill on a class trip to Tanzania.

Alice: Well in the hospital (---) it was just very sterile. I don't know, I just felt...I really wanted to go home (...) there was like a lot of testing, they gave me a bunch of chest x-rays and they had to draw out a lot of blood but I was severely dehydrated. And so they

couldn't get to any of my veins, and I'm really good with blood normally and I started crying and they had to take it out of my hand. And I was just like—I just felt totally broken down from all the people around me. But it was—you know they were trying to take care of you—but it was painful.

Although the many tests performed were to ultimately make her better, she describes feeling "broken down" by the people around her. Alice's account is consistent with Kleinman's description of a disjunction between treating disease and the experience of illness. While they did not treat her badly, the doctors and nurses were trained to pinpoint and treat the disorder, not Alice's experience of the disorder.

In Melissa's account of illness and recovery there is a similar sense of the treatment affecting her just as strongly as the sickness. When Melissa was nineteen years old she was diagnosed with lymphoma. Through chemotherapy, Melissa was able to overcome the cancer. When I asked Melissa about her experience in the hospital—if she had developed a relationship with the people who were treating her, Melissa answered.

Melissa: Ummm...well yeah, I think I did develop a relationship for sure ummm...but it was a lot less connected then I would have hoped. Actually, it was funny, while I was going through this I listened to this program on NPR about a relationship between a doctor and a patient and liked that they had written a book together. They had made such a strong connection and she was talking about the problems in our Western medical practices, that they were very disconnected and you sort of shuffle through and you can't really get attached because you see people die all the time. Versus you know, actually making some connection, but I felt....pretty disconnect from the medical people....the people I connected the most with were the nurses who actually were helping me when I was literally getting the chemotherapy drugs, just like the people who were around me. The doctor comes in, checks on you and runs away.

Alice and Melissa both report a general feeling of disconnect from those who were treating them---specially the doctors. Not only that, but Melissa also retells a story of a medical professional who seems aware of the problematic division between illness and disease. Melissa's description of her chemotherapy treatment gives a similar sense being systematically broken down.

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Melissa: Going through chemotherapy you have a huge, huge list of symptoms. Like you have nausea, you know, like you have irritable bowels, you have extreme fatigue, you have hair loss, you have these entire things—just endless amounts. And ---So they give you medicines to treat each one (laughs) which is extremely contradictory in itself. For instance this medicine Ativan is supposed to relieve nausea, but one of the symptoms is that it may cause nausea (laughs). But...I mean...as far as that goes....they treat each symptom butits not really....and then you know... I also went to other alternative healing practices...I like went to people in different fields that would suggest things to do.

Chemotherapy was what eventually saved her life, but the treatment itself was extremely traumatic. Often Melissa was taking medicines to deal with the symptoms of the treatment, not with her sickness. In Melissa's and in Alice's narratives both report feeling emotionally and physically drained from the process of the treatment. The main difference is that in Melissa's second narrative the symptoms of the treatment were directly related to the physical cure she was undergoing and therefore somewhat unavoidable. Alice's story of treatment and Melissa's first excerpt have more to do with the atmosphere of the hospital as well as with the attitudes of the

doctors and nurses. Kleinman's distinction between a focus on treating illness and disease is a theme present in both Alice and Melissa's narratives.

Still, Kleinman's break up of the Biomedical paradigm does not fully take into account personal variations of the lived experience of illness. This point is illustrated in Alice's account of her illness during her class trip to Tanzania.

Alice: Yeah, well I went to Tanzania and I got very sick in Tanzania. (...) Umm...but then it was this sort of interesting process of eliminating all the serve ' diseases I could have gotten. So like you know, I was first tested for malaria, and then I didn't have malaria (...) and then when I came back to the Untied States they hospitalized me. At first they thought I had a contagious dieses (...) possibly tuberculosis. Everyone had to wear a little suit when they came into the room. (...) Everyone thought this was pneumonia, if its tuberculosis, that is something really bad. Then things sort of got ruled out one by one and it turns out I ended up having the flu. It was sort of strange, an eighteen thousand dollar hospital visit for just having the flu. No one made me feel bad for that, but I just felt sort of silly. (...) There was a part of me—this sounds really bad---- I didn't want it to be just the flu.

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Going Green Eating Green

In this article we will focus on healthy eating and living. CCCS advises its interpreters to live a healthy-life style as interpreting requires a constant level of high focus and concentration, and places a lot of physical demands on the interpreter, such as standing for long periods of time.

Eating a well-balanced diet is a good first step to leading a healthy life style. A balanced diet includes eating daily portions of fresh fruits and vegetables, whole grains, low-fat dairy products, lean proteins, and drinking plenty of fluids such as water.

In addition to eating a well-balanced diet, you should also live a well-balanced life style which includes regular physical activities, and activities of relaxation. Please consider buying organic products from your local market or farm.





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It was like—I had gotten so sick. I had never been that sick ever before and it was a type of flu I could have gotten in the Untied States (laughs).

What is most noticeable about Alice's narrative is her focus on valid and invalid disease. During her trip Alice became extremely ill with a fever and incessant vomiting. Her sickness was pretty severe. In order to justify her disability Alice hoped that her sickness was something "legitimate", an exotic sickness that would cause such distress. It would seem that part of the stress of being ill was having a verifiable biological cause for the sickness. Yet, Alice did not just want any biological cause, she wanted one that could justify the severity of her illness.

It seems that within the Biomedical paradigm there is a hierarchy of illness. Legitimate illnesses are ones that are tied to a diagnosable bodily root. Within that level rests a division between sickness that are exotic or more serious and illness that are common and less noteworthy. In her interview Alice mentions the cost of the hospital stay "an eighteen thousand dollar hospital visit". It would appear as if the concern of cost is related to Alice's labeling of valid and invalid illness. Sicknesses that cost eighteen thousand dollars must be a disease legitimate enough to warrant the expense. The fact that Americans do not have free healthcare and are required to pay for medical bills through either private insurance or from their own pocket, impacts the way American's perceive illness and disease.

In an interview with Melissa the issue of health insurance was also brought up. During our discussion I asked her about whether she had health insurance to pay for the treatment.

Melissa: (Laughs) ooh yeah. If not you could never...I mean... I don't know what someone would do. I think that if someone didn't have health insurance they would die, to be honest. I mean (puhh) chemotherapy each time is five thousand dollars, I mean, its just absurd.

It is undeniable that the cost of the treatment and thus the availability of it impact the experience of illness. Part of the pressure of recovering is the financial cost of the sickness. Interestingly this pressure impacts the way a person perceives the disease and illnesses. The severity of the illness is important but somewhat less justified if the physical causes of the disease is deemed illegitimate. The structure of the American health care system commodifies both the worth of a human life and the experience of sickness itself. The experience of illness is tied to a financial cost and therefore creates a hierarchy of valid and invalid diseases.

The break up of the Biomedical paradigm described earlier

correctly identifies cultural themes and patterns that exist within the Western tradition of health and illness. Nonetheless, in the processes of describing the paradigm variations in experience are overlooked. For instance, in the case of the interviews above, the political economy of illness influenced the conception of disease into a hierarchy. This phenomenon is only an example of the culturally specific variations possible.

2.1 Ethnographic Work: Doctor

The description of the Biomedical paradigm as set out by Kleinman comes into question when compared to the personal account of Dr. Lieberman, an internist who specializes in rehab and Hospice care. As Dr. Lieberman explains, he treats patients that are too sick to go home but not sick enough to stay in the hospital. About one out of five of his patients go into hospice care.

According to Kleinman's description of the Biomedical paradigm a doctor sees his or her job as treating the disease. The psychological and sociocultural issues that arise with sickness are seen as extra. During the interview I asked the Doctor how he expected to help his patients. At first Dr. Lieberman addressed mostly issues of disease. He wished to figure out their chronic conditions and then provide medical supervision to minimize the effects of the conditions and finally, to help the patients go home or transition to comfort care. When asked how his expectations of treatment differed from that of the patients who came to see him. Dr. Lieberman answered:

Dr. Lieberman: It's different for every patient. And...you sort of have to work it out. Find out what their expectations are and then you let them.... you sort of...sort of... make a map for them as to what you think is going to happen and if they have questions about the map then they can ask you.

Dr. Lieberman appears to see two main components to his job. The first is treating the physical diseases afflicting his patients. The second is as a sort of a shepherd, a guide leading people through the map of their illness. Treating disease was undoubtedly important in Dr. Lieberman's approach, but the patient's experience of illness was not removed completely from the equation. When asked directly about the separation between disease and illness and if he treated issues of illness in his work Dr. Lieberman answered.

Dr. Lieberman: Its true....umm...and I think that umm... I have to say that my....my job...while....especially with families the issue of illness umm... comes up because umm its how people experience the disease and what it means in their life and....that we do deal with it but I

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would say that its still...its still seventy five, twenty five; seventy five disease and twenty five illness. And I would say that it would probably be better if it was fifty/fifty.

After explaining that he used to be a primary care physician, a job that required dealing with issues of illness much more regularly. Dr. Lieberman comments further on his current job and the relationship between issues of illness and family.

Dr. Lieberman: and in this work...it's a little bit easier...because they are so much sicker and so you can work on the disease part and you don't have to do the illness part all the time. The illness part really comes with the work with the families. Ummm for instance we have this lady who suffers from severe dementia that fell and broke some bones in her pelvis, and she has a daughter who is very involved. The work here really is to help the daughter realize that her mother was someone who really needed some supervision and the mother is going to assisted living. And so the work was really helping the daughter understand that and the patient was ok with that too. So that was a kind of illness work.

It would appear that issues of illness come into play when the disease or the symptoms of the disease comes into contact with the social. Unlike Kleiman's argument some doctors are not unaware of the importance of dealing with issues of disease. In terms of Dr. Lieberman's work, the doctor understands that part of the road to recovery is dealing with the emotional and practical impacts of the disease.

Issues of illness are not removed from treatment, but there is still a marked separation between disease and illness. The question now is, what function does this separation serve? Does the division between illness and disease impact treatment or is it simply too emotionally exhausting for the doctor to deal with both? After being asked if it was emotionally draining to treat issues of illness the doctor answered:

Dr. Lieberman: Yes and I think that umm...that people...when I think about illness and disease what I think about is...ahh...its finding out what it means to them and to figure out if there's something you can do to help that meaning. For instance, I can give you an example. I have a patient now who had surgery on her esophagus and she's learning how to swallow again and she can't swallow everything she wants to eat. And she can't swallow bread because bread is really hard on the esophagus. And so it turns out that she really does not

want to go home. She wants to stay in the facility even though she's swallowing and that she's able to take care of herself---she's able to get up and walk. And in talking with her discovering that her husband has Alzheimer's and so it's very difficult for her because she has to do the work of two people. And so she needs a break and there's the sort of unwritten, unexpressed piece for her. Umm, so we have to work with her to sort of work on what she gonna do to go home and what kind of things she can do to ask her family to help her a little bit more then usual, because she's really afraid to go home because of all the extra work it entails.

In the first case, the disease of a mother and the subsequent impact of that disease must be understood and accepted by the daughter. In the second story, the anxiety of a home environment impacts the recovery of the patient. Dr. Lieberman does not deny that he mostly addresses issues of disease, nor does he deny that incorporating illness can be more emotionally exhausting for the medical provider. Still in both stories, told by the doctor, treatment is very much connected to the patient's experience of illness. Along with treating the biological root of the disease, the doctor must understand and treat the meaning of the disease for the patient.

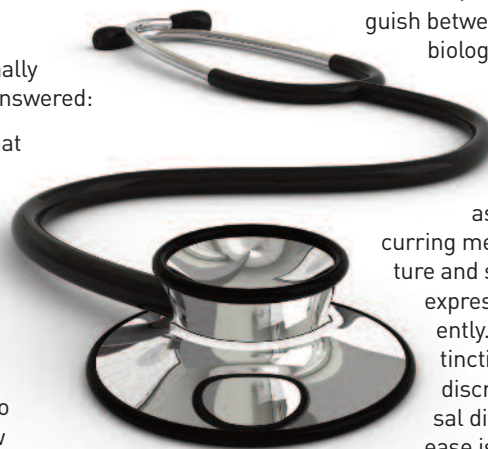
3. Perceptions of Mental Illness

The West's perception of mental illness is described in much the same way as the general structure of the Biomedical paradigm. The division between disease and illness, the body and the mind, continues into the realm of mental health. This separation is even more problematic with issues of mental health, as symptoms are often not tied to a tangible biological function.

Roland Littlewood (2002: 5) writes that psychologists distinguish between the pathogenic or biological reasons behind mental illness and the pathoplastic, the personal and cultural variations of disease.

The basic theory behind psychology assumes that there are some sort of reoccurring mental disorders that are similar in structure and symptoms. Yet, very often people express these "unformed" disorders differently. The pathoplastic and pathogenic distinction was formulated to explain these discrepancies. The pathogenic is the universal disorder, the pathoplastic is how the disease is expressed culturally and personally.

Once again one sees the division between "neat" sci-



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ence and messy personal relations. A mental illness is tied to a certain set of physical reactions, causing a condition that is expressed through and by a person's personal relations. The current model of psychiatric illness, "may be described as something like a Russian doll: the essential biological determinants which specify an illness are surrounded by a confusing series of cultural and idiosyncratic envelopes which have to be picked away in diagnosis to reveal the real disease (Littlewood.2002: 7).

This model comes into question when one realizes that many of the mental disorders listed in the DSM such as borderline personality disorder or paranoid personality disorder are not tied to any particular biological cause. In effect, the distinction between the pathogenic and the pathoplastic causes of illness is arbitrary. Often the cause of a mental illness is rooted in the pathoplastic. Yet, those illnesses with no direct correlation to a physical cause are often thought to be less legitimate than those that are directly tied to the pathogenic.

A key element in this distinguishing of real (biological) disorders and "unreal" (not biologically based) disorders is the issue of blame and responsibility. As Littlewoods (2002:4) writes: *When the new 'nervous specialists' and 'alienists' were called to deal with patterns of distress or unusual behavior among people who could not be obviously recognized as physically diseased or insane, they were faced with a practical issue of deciding if the patient was responsible for their symptoms; and whether they were accountable when making a will or giving evidence in a court of law, or if they could be expected to take responsibility for criminal acts or for rearing their children.*

Members of society are required to uphold certain social rules. If someone was to break these rules, such as by committing murder, they must face the consequences. A person is only excused if they were hindered by "real" mental or physical handicap. The tendency to label illness that is not tied to a real biological disorder as illegitimate, ties back to this social need to determine if someone can be held responsible for his/her actions.

Like Kleinman's portrayal of the Biomedical paradigm for general physical health, Littlewood's description of the Biomedical paradigm of mental health and illness is based on a division of illegitimate and legitimate causes. Both paint a picture of the paradigm as static and unvarying.

4. Ethnographic Work: Mental Illness

My ethnographic work for the paradigm of mental illness showed similar results as my research for general health. My interlocutors' depiction of mental health shares many of the same patterns present in Littlewood's writing. Some

psychological disorders are due to chemical or physical reactions, others are a result of more mysterious, "messier causes".

My interviewees were aware of the sometimes physical causes of mental illness but for the most part, they saw mental illness as something too complex, too shifty to fully pin down and understand. In one interview I asked Camellia a sophomore from Sarah Lawrence originally from Seattle, to define mental illness using her own criteria. Camellia answered as follows.

Camellia: Ummm...I think?.....I think there's a lot....I think that's really complex. Well obviously I think that mental illnesses are probably to complex for me to... .for anyone to spot umm precisely... (....) umm...there would have to be some sort of evidence that they're unstable and that maybe their mental tendencies relate somehow to they're physical tendencies.

In her response Camellia expressed her ambivalence in trying to correctly label or explain mental illness. Camellia, like many others in the United States, correctly understands the basic functioning of the human body. She can explain about nerves, germs and the role of the body's many organs. While people may have a general understanding of how the mind works and the basic theory behind psychological practices, they are still uncomfortable with trying to explain about their understanding of mental illness. When asked the same question Melissa also expressed a similar sentiment.

Melissa: Umm.....well obviously there's different severities. I mean I don't have the skills to identify it necessarily— anything accurate. But umm...When someone really can't function to like the expectations of everyone around them. When they really have to be assisted. (...) well I think there's a difference between mental illness and being a little bit mentally challenged.

Mental illness and general bodily health are viewed as two different categories. Issues of mental illness are seen as something almost mystical. The mind is viewed as something too complex, too interconnected to be fully understood and broken down, in contrast to views of the physical body. Neither Camellia nor Melissa are trained doctors, yet they seem much more confident explaining how to combat a disease. Part of this is because Science does not quite know how to fully explain mental illness and so it is not fully incorporated into the biomedical paradigm. The only one who seemed more comfortable to address issues of mental illness was Alice, who has a background in Psychology.

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Alice: Umm....I guess...I use...the criteria of something is basically starting to interfere with your life and your relationships. So....I mean....the thing is....with mental illness we all have fluctuations in our mental state, just like we all have fluctuations in our physical state. I would deem it mental illness when your not, your not able to do the thing that you would like to do and its somehow preventing you from functioning.

Littlewood's basic theory behind Western perception of mental illness can be applied to my interlocutor's interviews. The interlocutors have a sense of physical causes of mental illness, as well as an understanding of the more mystical or messier workings of the human mind. What Littlewood's theory does not take into account is the specific cultural impact on the individual's understanding of and interpretation of the Biomedical paradigm.

This can be seen later in Camellia's interview when she spoke further about her ambivalence to personally label someone as mental ill.

Camellia's: I kind of have a hard time with mental understanding, mental illness because II ...think... ..in our generation maybe there's (laughs) I don't know (high pitched) I feel like its maybe over-exaggerated in some cases., its like over.... depression and certain mental illness are over diagnosed. Ummm not that it should effect my understanding of what mental illness is.....it does, it does effect my understanding of it I think, it skews it a little bit, I mean umm. But then when you get into the idea of schizophrenia or something else that is super super complex...umm....(...) depression, ADHD , and bipolar disorder seem to be overly generalized and overly diagnosed. I mean there's evidence that they are and I think that the simple presence of that in our culture would skew mine or anyone else's idea of what ADHD or depression is.

It would appear that a leading factor in contributing to Camellia's ambivalence towards categorizing issues of mental illness has to do with the frequency with which mental illness is diagnosed within her society. Camellia's ambivalence towards labeling mental illness is not just due to the separation between pathoplastic or pathogenic causes, or a sense of general complexities of the mind. It is directly related to the cultural norm of her society. Most of Camellia's personal experience with mental illness has been the seemingly over diagnosis of disorders amongst her peers. This is a markedly

² It is important to note that ADHD is not a mental illness but a learning disability.

different cause for Camellia's ambivalence towards labeling mental illness than simply Littlewood's separation between pathoplastic and pathogenic roots.

5. Conclusion

In the processes of formulating lived experiences into academic, structured paradigms the intricacies of the phenomenon are lost. This is the bargain of representation, the gist of an experience or social paradigm maybe described but certain details must be overlooked. In the case of Kleinman and Littlewood's writing on the Biomedical paradigm, the authors did not fully articulate the fluidity of their subject.

However, the patterns in the Biomedical paradigm described by Kleinman and Littlewood appear in my ethnographic work. My interlocutors describe a tendency towards perceiving dichotomies, specifically the division between disease and illness, and pathoplastic and pathogenic causes of mental illness. Also they describe a general focus in the medical field on treating disease, as opposed to illness.

While elements of their interviews supported Kleinman and Littlewood's theories, they also revealed that the authors' portrayal of the biomedical paradigm was not fully representative. The structure of the Biomedical paradigm takes on different meanings depending on the cultural context of the situation. In the cases of Melissa and Alice, their concept of disease was formed into a hierarchy due to the political economy of illness within the United States. The interview with Dr. Lieberman revealed that issues of illness were not completely removed from the medical profession. Finally, Camellia's confidence in labeling and categorizing mental illness was deeply impacted by the high rate of diagnosis within her society.

It cannot be expected for two authors to fully capture the many cultural variations of a particular paradigm. Yet, in their writing it is essential that authors, especially anthropologists, acknowledge the possibility for variation within theories.

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President's Corner

Dear interpreter:

If you were trained by CCCS, you most likely heard about the concept of illness and disease. Here the illness deals with the entire person and the disease with the "broken" piece.

Dr. Arthur Kleinman is a world renowned physician and anthropologist in the following health care areas: medical anthropology, cultural psychiatry, global health, social medicine, and medical humanities. He has been associated with Harvard University for over 30 years and he has done extensive research in China and Taiwan. He has authored multiple books and articles. Below is a short list of the books he is recognized for:

DR. KLEIMAN THROUGH HIS
EXTENSIVE RESEARCH AND
FIELD WORK GUIDED PROVIDERS
ON HOW TO RETHINK OUR BIO-
MEDICAL APPROACH TO
HEALTHCARE

- *Medicine in Chinese Cultures: Comparative Studies of Health Care in Chinese and Other Societies*: papers and discussions from a conference held in Seattle, Washington, U.S.A., February 1974 / edited by Arthur Kleinman ... [et al.]. -- U.S. Dept. of Health, Education, and Welfare, Public Health Service, National Institutes of Health, 1975.
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To find out more about Dr.Kleinman check

http://www.fas.harvard.edu/~anthro/social_faculty_pages/social_pages_kleinman.html

Dr. Kleinman through his extensive research and field work guided providers on how to rethink our biomedical approach to healthcare and promoted an inclusive approach that addressed the mental health and the medical well being of our patients as an interconnected field. He was a pioneer in developing a tool to assist providers on how to engage a patient with perhaps different expectations and views on the patient doctor relationship. The 8 questions a provider may ask a patient are:

5. Illness	Down
2. Chemotherapy	
1. Sterile	
8. Esophagus	
7. Hypertension	
6. Dehydration	Across
4. Disease	
3. Chronic	
1. Sodium	
Answers to the CCCS Crossword - August 2011	

President's Corner

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1. What do you call the problem?
2. What do you think has caused the problem?
3. Why do you think it started when it did?
4. What do you think the sickness does? How does it work?
5. How severe is the sickness? Will it have a short or long course?
6. What kind of treatment do you think the patient should receive?
What are the most important results you hope to receive from this treatment?
7. What are the chief problems the sickness has caused?
8. What do you fear most about the sickness?

These questions have served as a stepping stone to other cross cultural interactions between patient and providers.

Over 30 years ago when I worked as a full time interpreter at a local hospital, I interpreted for a Portuguese woman who had given birth by herself to more than ten children. Often her labor was quick and if she was working in the fields, she would go under a tree, push her baby, cut the umbilical cord, push the placenta out, wrap the baby in her clothes and walk to her home and rest and wait for the women in the family to take care of her.

She was an amazing, strong and self-sufficient woman. She had come to the hospital with some abnormal vaginal bleeding, her first time seeking medical attention, she described herself as always healthy. In the USA, she worked at a local factory, indoors and she associated some of her health issues with not being outside and breathing the fresh air. After a few exams, it was concluded that she had to remove her uterus and ovaries, a simple procedure, at that time, a week in the hospital and she could return to work within a few weeks. The tumors were most likely non-malignant, but big enough to bother her.

The doctor very nicely focused on her hysterectomy, told her about potential side effects, potential need to be on some hormone therapy and the patient agreed to have the surgery. This was no big deal for the provider or for the patient, compared to what she had gone through this was not even a bit as complicated. The provider, in this case the surgeon, dealt with the disease, he didn't have any dialogue about how this surgery was perceived by her or how she felt about it. This patient never recovered from the hysterectomy, she became very depressed, never returned to work, where she used to feel proud of her new work in the USA. After many outpatient visits and psychiatric consults to deal with some psychosomatic new symptoms, eventually we lost this patient. I always think what if the provider had gotten to know her a bit better? I believe at this time he missed asking the following questions.

4. What do you think the sickness does? How does it work?
5. How severe is the sickness? Will it have a short or long course?
6. What kind of treatment do you think you should receive? What are the most important results you hope to receive from this treatment?

The art was in how to ask these questions in a non-linear way so that the patient would not lose trust in the medical provider as the expert. For this patient losing her most important organs, in some ways she had a lay understanding of how they worked and seeking help outside of her group of women, was a sign of serious sickness. Although, not in the mind of the provider who was recommending a hysterectomy as a proactive measure to lessen her pain, bleeding, discomfort and possibly later on, a miss of something more serious.

As interpreters, we cannot act as providers, but at some point interpreters must be part of the team presenting the patients that one has interpreted for so that one can serve as a culture coach. Enjoy your research and reading on the concept of illness and disease.

Zarita

Know your Acronyms and Abbrev.

BM	Bowel Movement/Bone Marrow
BS	Bowel or Breath Sounds
CP	Chest Pain/Cerebral Palsy
CNS	Central Nervous System
DM	Diabetes Mellitus
FBS	Fasting Blood Sugar
FU	Follow up
HA	Headache



Ask Dr. Lane

What is so important about decreasing Salt in our Diet?

For many years, it has been recognized that Salt in the diet, can lead to or worsen high blood pressure. During a time, say 40 years ago, there were only a few medicines available to control high blood pressure. During that time there was a lot of emphasis on non medicine approaches because there were a limited number of medicines to control high blood pressure.

As the years passed, more and more drugs for blood pressure control were developed. With more drugs to use, there was less and less emphasis placed on diet. Why diet when all you have to do is take a pill and accomplish what you are trying to do?

Now it is becoming recognized again that the amount of salt in the American diet is simply too much. Salt is found naturally in foods, but a lot is added during processing and preparation. The average American eats five or more teaspoons of salt each day. This is about 20 times as much as the body needs. In fact, your body needs only one-quarter of a teaspoon of salt every day. The current recommended daily salt intake is 5.8gm per day, (Less than 2300mg of sodium.) One gram of salt contains around 400mg of sodium. It is recommended that adults with hypertension have less than 3.8gm/day of salt or less than 1500mg. However, when we look at what most Americans consume, we find that it is around 9.4gm per day or 3700mg of sodium. Men between the ages of 16 and 50 eat around 12grams of salt per day. Women in the same age range consume 7gms of salt per day.

Where is the salt? In the American diet 80% of the salt we eat comes from processed or pre-prepared foods. What single food category is responsible for the majority of salt in the U.S. diet? Go ahead, pick one: soup, snack foods, bread, tomato sauce or pizza? Well, would you believe bread? 37% of salt comes from cereal and cereal products, 28% comes from meat, poultry, fish products, 12% from vegetable products like soup, tomato sauces and potatoes, and finally 8% of salt comes from milk and milk products.

Why do food manufactures use so much salt? It acts as a preservative. It also is an inexpensive way to add flavor. We are used to eating very salty foods. It starts when we are infants eating baby food with added salt. Studies suggest that in six to eight weeks one can unlearn the need for salty taste in one's food.

Lowering the amount of salt that one eats can significantly lower their blood pressure. If one can drop the amount of salt by 3grams per day, one can reduce the incidence of coronary heart disease. In fact, there is significant lowering of death events with a 3gm/day reduction in the intake of salt. The National Sodium Reduction Initiative calls for a 50% reduction in the amount of salt used in restaurants and processed foods in 10 years. This in turn would lead to a 40% reduction of the population's intake of salt which would decrease the blood pressure of the population enough to save 150,000 lives each year.

CONTINUED

Here are some tips for decreasing salt in your diet:

- Read food labels
- Stick to fresh meats, fruits and vegetables instead of packaged counterparts
- Avoid spices and seasonings that contain sodium
- Check restaurant websites and request that your food be prepared without added salt
- Cook rice, pasta and hot cereals without salt
- Choose ready to eat cereals with low sodium cereals
- Rinse canned foods to remove extra sodium
- When available, buy the low sodium, reduced sodium or no-sodium version of foods
- Be creative and season your food with spices, herbs, lemons, oranges, wine and Tabasco sauce. Remove the salt shaker from the table



Ask Dr. Lane (CONTINUED FROM PAGE 5)

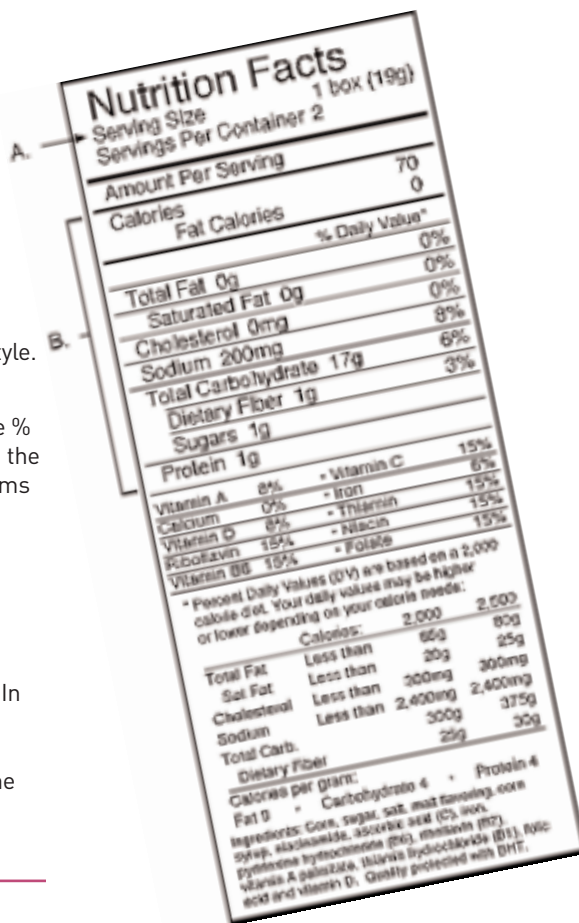
Learning to read food labels

Food labels are standardized by the U.S. government's National Labeling and Education Act (NLEA). Nutrition labels and an ingredient list are required on most foods so you can make the best selection for a healthy lifestyle.

- A. The serving size represents the typical amount eaten by an adult.
- B. The sodium content is listed on the food label per serving size. Ignore the % daily value and focus on the amount of mg sodium per serving. Decrease the total amount of sodium you consume to 2,300 milligrams (mg) or 2.3 grams (g) per day.

Low sodium = 140 mg or less per serving
 No sodium = less than 5 mg per serving

In summary, in just six to eight weeks, one can unlearn the need to eat salty foods. Studies have shown that the consumption of salt in the diet is directly related to the burden of developing cardiovascular and hypertensive disease. In fact, the correlation is so strong, that some scientists think that eating a high sodium diet has an effect on increasing death rates that is independent of hypertension. By reading labels and choosing foods that are low in sodium one can decrease sodium intake, decrease high blood pressure and add precious years to one's life.



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http://my.clevelandclinic.org/healthy_living/nutrition/hic_low-sodium_diet_guidelines.aspx

Vocabulary-ADHD

Attention Deficit Hyperactivity Disorder	A learning disability causing difficulties with attention and concentration that begins in childhood and no later than adolescence.
Ambivalence	Uncertainty or fluctuation especially when caused by the inability to make a choice or by a simultaneous desire to say or do two opposite or conflicting things.
Blood pressure	It is the force of the blood pushing against the walls of the arteries. Blood pressure is measured in millimeters of mercury. Blood pressure numbers are written like this: 120/80. Systolic pressure is the top number which shows the maximum pressure in the arteries when the heart contracts. Diastolic pressure shows the minimum pressure in the arteries when the heart is at rest.
Hypertension	It is high blood pressure which means that the blood is moving through the arteries at a pressure higher than normal.
Idiosyncratic	It pertains to something peculiar to an individual.
Migraine	Headache characterized by pain in the head (usually unilateral) vertigo, nausea, vomiting, photophobia, and scintillating appearances of light.
Paradigm	A set of forms all of which contain a particular element. An example serving as a model or pattern.
Pathogenesis	The pathologic, physiologic, or biochemical mechanism resulting in the development of a disease. Pathogenic – the biological reasons that cause a disease.
Schizophrenia	A common type of psychosis characterized by a disorder in the thinking processes, such as delusions, and hallucinations, and extensive withdrawal of the individual's interest from other people and the outside world. It is considered a group of mental disorders rather than a single entity.



Upcoming Trainings/Courses

GETTING READY FOR YOUR WRITTEN HEALTHCARE CERTIFICATION EXAM

This course will help prepare active qualified healthcare interpreters for both of the national certification written exams. In order to simulate the written certification exams, students will have the opportunity to take online tests during class time. These exams will help prepare the student to get the feel of how the certification exam will be presented and will allow them to receive instant feedback on their progress. Students will be able to use these exams as a tool to help gauge their progress, and as an indicator to help them determine their readiness for the certification exam. [Click here](#) for a complete overview of the course.

Online as of December 2011

THE ART OF MEDICAL INTERPRETATION: 60-HOUR CERTIFICATE PROGRAM

Pre-requisites: Applicant must be at least 18 years of age, with a minimum of a HS diploma or GED, and must pass a mandatory screening examination in English and the target foreign language(s) prior to acceptance in the program. Applicants must pass the screening at a minimum of "Advanced Mid-Level," according to the industry standards. [Click here](#) to download the catalogue. If you are interested in more information please contact us at 781-729-3736 or by email, info@embracingculture.com.

The American Translators Association has approved the Art of Medical Interpretation 60-hour training program for 10 Continuing Education Points.

Woburn, MA : Tuesdays and Thursdays, Nov. 29, 2011-Jan. 31, 2012, 6pm-10pm

The Fundamentals of Legal Interpretation: 60-hour Certificate of Attendance Program

Pre-requisites: Applicant must be at least 18 years of age, with a minimum of a HS diploma or GED, and must pass a mandatory screening examination in English and the target foreign language(s) prior to acceptance in the program. Applicants must pass the screening at a minimum of "Advanced Mid-Level" according to the industry standards. There is a \$55 non-refundable fee for this screening examination. If you are interested in more information please contact us at 781-497-5066, or by email at info@embracingculture.com.

Cost: \$795 (materials are not included)

Sundays 9:00am-2:00pm, September 11, 2011-December 11, 2011

The American Translators Association has approved the Fundamentals of Legal Interpretation: 60-hour Certificate of Attendance Program for 10 Continuing Education Points.

Upcoming Conferences October 2011

October 26-29

ATA 52 Annual Conference

Marriott Copley Place
110 Huntington Avenue
Boston, Massachusetts 02116
www.atanet.org

Zarita Araujo-Lane LICSW &
Dr. Rick Lane will present

"Learning Medical Terminology Through Medical Case Studies"

Date/Time of Session:

**Friday, October 28, 2011
2:30pm-3:30pm**

Interpreter Award of Excellence

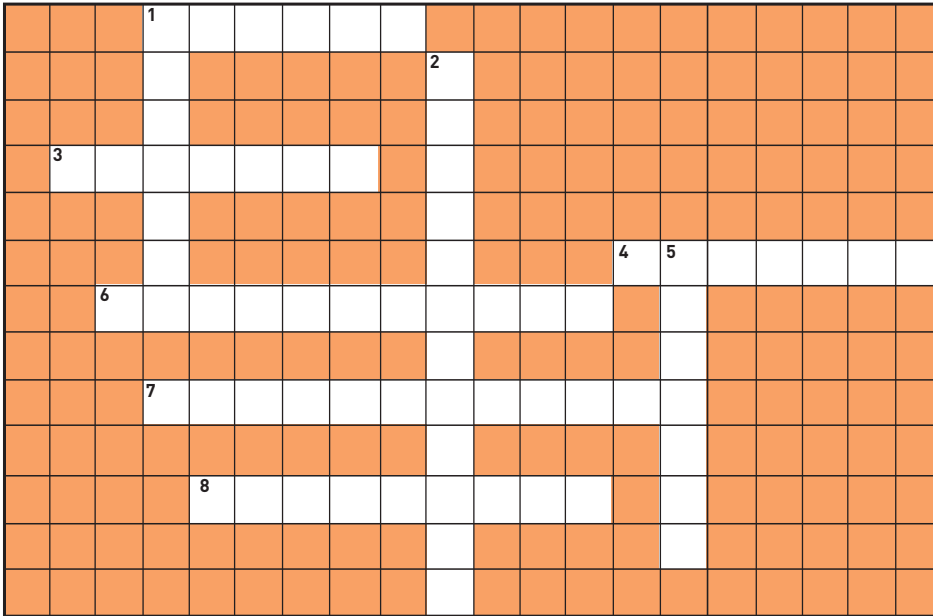
Desmand Lam

"Being a medical interpreter not only can help LEP patients but also gives me a sense of fulfillment. It has been a great pleasure working with the professional and understanding team from CCCS. With such exceptional support, I am able to utilize my language abilities to help those in need.

During my leisure time, I love to read and play table tennis. Reading about what is happening in the world everyday has become my interest since I was young. Whenever I have time, I also love to play table tennis because the sport is fast and it demands quick reactions.



August Crossword



ACROSS

1. salt
3. of long duration
4. abnormalities in the structure and function of body organ and system
6. reduction of water content
7. high blood pressure
8. portion of digestive canal between the pharynx and stomach

DOWN

1. aseptic, free from all living microorganisms
2. treatment of disease by means of chemical substances or drugs
5. the lived experience of sickness.

Created by puzzle-maker.com
Answers to the crossword are found on page 8.

CCCS Interpreters please go to www.embracingcultureonline.com to take your continuing education quiz.

English Idioms Explained

Idiom	Explanation	Example
Eyes peeled	To be aware	I will keep my eyes peeled for any new developments.
Barking up the wrong tree	Not looking in the right spot	If you think that I know anything about who did it, let me assure you that you are barking up the wrong tree.
The more the merrier	The more people involved, the better	I asked Mr. Abdul if he wanted help moving and he said; "the more the merrier."
Too many cooks spoil the broth	The results are poor when too many people take the lead	Too many cooks spoil the broth is what I always say when the family gets together and everyone comments on how the lasagna should be prepared.
Helter skelter	Lack of organization	When I arrived it was so hard to find the document that I was looking for because everything was left all helter skelter