# Cultural Perceptions and Nutrition

**PATRICIA A. CROTTY**
**and MARK L. WAHLQVIST***
**Geelong, Victoria**

It is important to understand food in human as well as in nutritional and medical terms. Insights provided by an anthropological approach to food and illness are helpful in developing techniques to provide an understanding of the patient's experience of food. It is increasingly difficult for both professionals and lay people to sort out fact from fiction in nutrition. This has led to a number of consequences, from the exploitation of patients to the adoption of unscientific practices by some doctors.

* PATRICIA A. CROTTY is Lecturer in Nutrition, Deakin University, Geelong, on secondment as Program Director, Victoria's Food and Nutrition Project.
Prof. MARK L. WAHLQVIST is Foundation Professor of Human Nutrition, Deakin University, Physician-in-charge, Clinical Nutrition and Metabolism Unit, Prince Henry's Hospital, Melbourne, and Chairman, Steering Committee, Victoria's Food and Nutrition Project.

## Role of the Doctor

Doctors advise their patients about food and are seen as reliable sources of such information [1]. Helman's 1984 study of general practitioners [2] indicates that for his sample of nearly 800 Australian GPs nutritional advice was given to 13% of their patients. Obesity, diabetes, cardiovascular disease, arthritis and tiredness were nominated by 75% or more of the GPs as conditions for which they gave this advice. The results of the survey suggest, among other things, that many more people could get dietary advice from their doctor, if doctors were more willing to give it, particularly in the context of an overall healthy lifestyle.

In encouraging doctors to become more involved in nutrition counselling we would offer 2 pieces of advice:

1. *Effective nutrition advice, i.e. scientific advice which patients put into practice, requires an appreciation of the patient's understanding.*
2. *Such an appreciation does not necessarily make patient care easier, although it may make it better.*

The rest of this article gives some background and practical techniques for those who wish to introduce nutrition conselling into their clinical practice.

**The translation between popular and professional medical subcultures is a major function of the general practitioner**

## Culture and Nutrition Counselling

The term 'culture' includes any patient's 'folk medicine' concepts. In clinical practice, discussions of culture in relation to illness are frequently seen as 'interesting' rather than of practical importance in clinical decision making. However, an understanding of the differences between a practitioner's professional knowledge of 'a disease' and the patient's experience of 'an illness' should be part of everyday clinical reasoning.

Practitioners are involved everyday in translating 'lay' concepts of illness and body function into clinical terms. Good and Good believe that this 'translation between popular and professional medical subcultures' is a major function of the general practitioner, and the consequent mutual process of understanding and interpretation is 'a basic element in effective healing' [3].

Further, we consider that the extent to which practitioners are unable to use their understanding of these differences is reflected in at least 2 current problems:

1. The flight by some practitioners into 'alternative' practices which may give the doctor more satisfaction but not necessarily give the patient better care: this is the dilemma referred to by Pelegrino as the balance between competence and compassion [4].
2. 'Difficult' behaviour by patients such as non-compliance and dissatisfaction.

Examples of quotations from patients, which illustrate the need to translate across health models arising from different ways of thinking, include: 'It feels like something is pressing on my chest', 'My liver's been playing up', 'I can't eat tomatoes because they're too acid for my arthritis', 'I get depressed because of my hypoglycaemia', 'If I took the water tablets I'd never be able to get the tram to town'.

Being able to make use of these 'translations' is particularly appropriate in nutrition because food is the focus of intense cultural, social and psychological meaning, and a basic component of lifestyle and quality of life. We advocate that doctors actively seek out the patient's explanation of their problems in relation to food. Patients' 'explanatory models' [5] can be elicited in the expectation that patient – practitioner communication will be enhanced and that the practitioner will be able to make more appropriate decisions about patient education and treatment, especially where the patient's view conflicts with the practitioner's (table I).

These considerations are particularly important where food is a basic part of treatment, e.g. diabetes or obesity. In these circumstances, understanding the patient's view of food may be crucial to therapy. It is clear that some patients believe that food is part of an illness, either as a cause

***TABLE I.*** ***Questions to elicit 'explanatory models' and lifestyle factors***

| | |
|---|---|
| Why did you come to the surgery today? | What are the chief problems your sickness has caused for you? |
| What do you think has caused your problem? | How are you treating your problem? How do these treatments work? |
| Why do you think it started when it did? | What part does food play in your problem? |
| What does your problem do to you | Does your problem affect what you eat? |
| What's going on inside you | Is it helpful to change what you eat? How does this work? |
| How severe is it? Do you expect it to have a long or a short course? | Can other people help you? How? |
| What do you fear most about your sickness? | |

or a cure. For many patients, concepts of food exist within a well organised framework of religious, ethnic or ideological ideas, e.g. Jewish or Islamic food law, or the Pritikin diet. In these circumstances understanding how food is connected to other areas of the person's life may well be crucial in offering advice about changing current eating behaviour. For example, an overweight person who is a Muslim and presently distressed about family relationships may view a prohibition on the consumption of sweet foods as particularly bewildering. Honey is viewed as easing mental suffering in Islamic cutures, and dishes made with honey are often eaten at Moslim funerals. Helping such a person control their energy intake will require a more complex interaction than an injunction to cut out sweets.

Such an approach to understanding the patient's view of food is valuable for:

1. *Determining what issues are of most concern to the patient*
2. *Determining what problems are associated with food for the patient*
3. *Providing a basis for patient education and exploring potential problems of compliance.*

## *Working with Differences*

### Self-Care and Food

The work of Kestin et al. [6] illustrates that in the area of chronic disease patients coping with their illness often favour dietary means of self-treatment. Being able to eat the food one likes or that embodies hope, in circumstances one prefers has great potential for contributing to feelings of well-being, and contributes considerably to the perception of quality of life. The reverse is also true: being forced, by whatever circumstances, to eat disliked food, to be deprived of favoured foods or to be powerless to get what one feels is necessary, can be extremely distressing. The role which food, and interchange about it, serves in exchanges between health care providers and between providers and patients has been discussed [7]. This work refers in particular to institutions, but the issues are relevant to patients in a community setting. Wherever it is possible for the GP to assist people in self-care and autonomy these opportunities should be taken. The non-nutritional functions of food rival the nutritional functions in their impact on human health and well-being. At the same time, to allow a patient to make an obviously risky choice in nutrition without some attempt at informing and even persuading them to abandom such a course is unacceptable.

### Patient Education

The incompatibility between the patients' views and biomedical knowledge is not, by itself, sufficient reason to seek to change the patients' beliefs; but, where the patients' beliefs may have detrimental consequences, information giving and persuasion are an important part of the GP's role. In this case a knowledge of how the patient views food in relation to their illness assists in under-

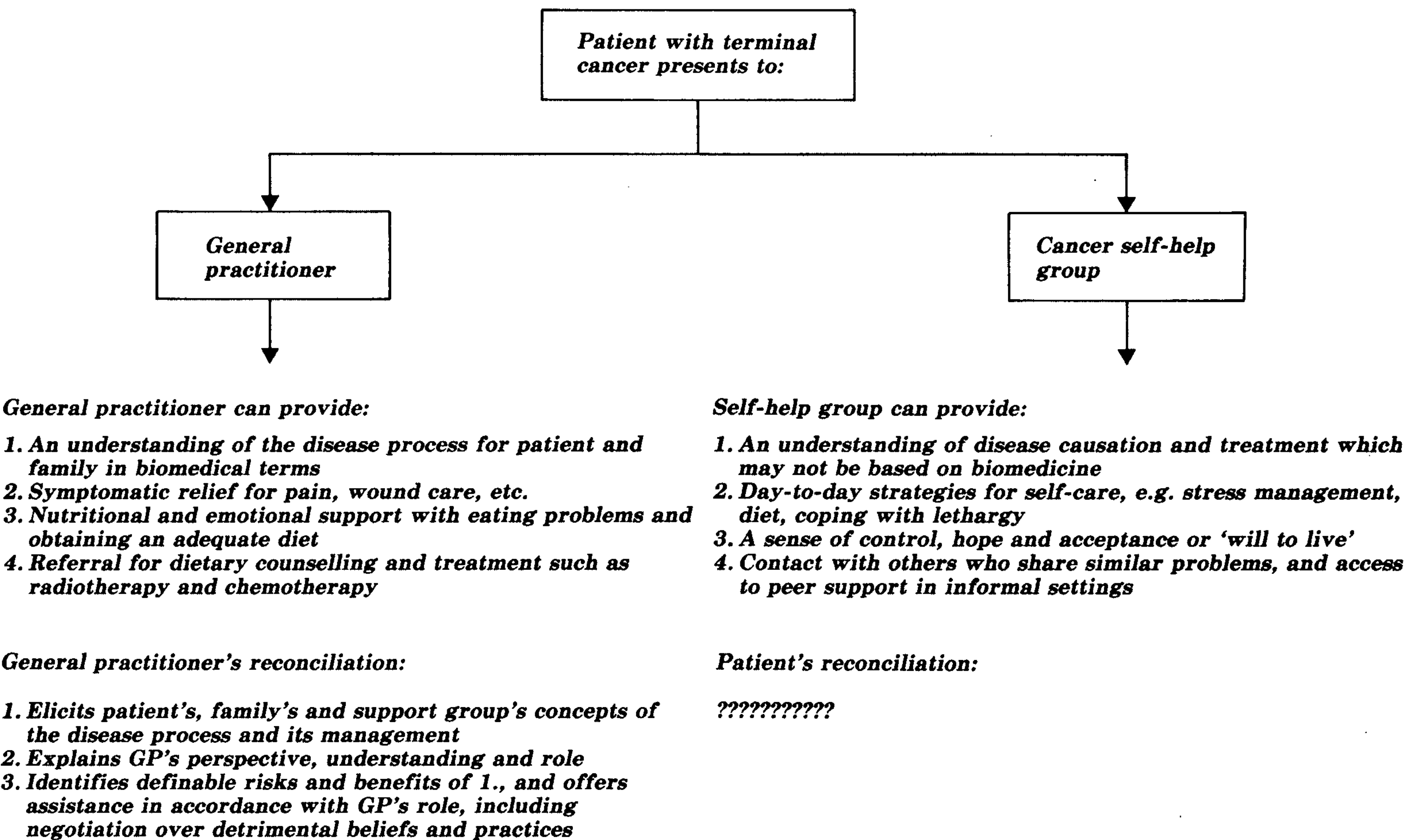


*FIG. 1. The general practitioner's dilemma.*

standing patient's concerns and behaviour and in giving appropriate explanation. Kestin et al. have detailed the extent to which dietary manipulation is used by patients with rheumatoid arthritis as a form of self-care and stress the importance of the doctor's awareness of these practices combined with appropriate patient education.

Figure 1 provides an illustration of the dilemma of a GP managing a patient engaged in a non-biomedical explanatory model.

In circumstances where it is important to attempt to 'negotiate' some meanings with patients, an appreciation of what is unique about a patient's view of food is invaluable.

## *An appreciation of what is unique about a patient's view of food is invaluable*

### Case Example: An Explanation Based on Negotiation

A woman has a present bodymass index of 21 and with a recent weight loss of 2kg presents and declares: 'I'm on the Pritikin diet to stop my cancer'.

GP's possible response:

1. Use relevant questions in table III to learn more about patient's 'explanatory model' or cancer and its relation to food.
2. Give information on:
   - The extent to which the patient's cancer can be influenced by diet
   - The importance of good nutrition generally to the patient, reinforcing the patient's wish to choose foods helpful to her present condition
   - The relevance of weight loss for the patient (weight loss is often a consequence of the Pritikin regimen).
3. Accept continued abstention from salt and coffee but institute a higher energy level in the diet by including sweet foods and more meat.
4. Offer referral to a dietitian if appropriate, e.g. if the dietary changes are difficult to implement, i.e. detailed counselling required, new recipes, cooking methods or long term support needed.

## *Conclusion: Food and the Caring Environment*

The nature of the caring environment is critical and part of this environment is the provision of food and information about it in relation to illness and health. The challenge of balancing competence and compassion in medicine today is reflected in nutrition care concerns. Issues seem to centre around problems of:

- What is realistic and scientific to believe good nutrition can do for patients
- What patients can do for themselves through good nutrition
- The acceptance by some doctors of unscientific nutrition concepts (compassion without competence)
- The unwillingness of some doctors to offer nutrition counselling themselves and/or reluctance to make referrals to dietitians (competence without compassion)

Some possible strategies to deal with these problems are:

1. Elicitation of patients' explanatory models of their illness and the role food plays in it, especially by GPs
2. Translating across biomedical and non-biomedical models by doctors to improve communication with patients
3. Negotiating with patients when food beliefs and practices are detrimental to the patient.

## *References*


1. Worsely A, Crawford D. Beliefs about food, nutrition and health – A brief review of five Australian population surveys. Proceedings of the Fourth National Conference of the Dietitians Association of Australia Academy of Science, Canberra, 1985
2. Helman AD. Nutrition counselling. Australian Family Physician 14 (12): 1290, 1985
3. Good BJ, Delvecchio Good M-J. The meaning of symptoms: A cultural hermeneutic model for clinical practice. In Leon Eisenberg and Arthur Kleinman (Eds) The relevance of social science for medicine, p. 165, D. Reidel, Dordrecht, 1981
4. Pelegrino ED. Being ill and being healed. Some reflections on the grounding of medical morality. In Kestenbaum V (Ed.) The humanity of the ill phenomenological perspectives, University of Tennessee, Knoxville, 1982
5. Blumhagen D. The meaning of hypertension in clinically applied anthropology. In Noel J. Chrisman and Thomas W. Maretzki (Eds) Anthropologists in health science settings, D. Reidel, Dordrecht, 1982
6. Kestin ML, et al. The use of unproven remedies for rheumatoid arthritis in Australia. Medical Journal of Australia 143: 516, 1985
7. Crotty P. Physical disability: Psychosocial factors in feeding and eating. Proceedings of the Nutrition Society of Australia: 168, 1981

# Introduction

**MARK L. WAHLQVIST***
**Melbourne**

The application of nutrition science to clinical medicine is increasingly important. The problem about 'clinical nutrition' from a learning point of view is that it is so multidisciplinary; it requires a knowledge of agricultural practice, food processing, food habits, food composition, nutritional biochemistry and physiology, the peculiar problems of different age groups and physiological states, paediatric, adolescent and geriatric, in pregnancy and lactation, of public health nutrition and of therapeutic nutrition. Most of all, nutrition ultimately has to do with food, a subject which traditional medical curricula scarcely allow to intrude, while proceeding directly to nutrients. In this series, an understanding of food will be provided, as will the relationships between overall dietary pattern and disease pattern. In this way, the rationale for national dietary guidelines will become evident as will the bases for various therapeutic nutrition manoeuvres.

* MARK L. WAHLQVIST is Professor of Human Nutrition at Deakin University, Geelong, Victoria. He is also Physician-in-Charge, Clinical Nutrition and Metabolism Unit, Prince Henry's Hospital, Melbourne.