EDITORIAL

Sociocultural Influences on Disease Perception

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Differences in the prevalence and natural history of diseases between races have been well recognised. The prevalence of Hepatitis B infection, nasopharyngeal carcinoma and systemic lupus erythematosus for instance, is relatively high among the Chinese as compared to the Malays and Indians living in apparently the same community. Black Americans have a higher prevalence of hypertension than Whites[1]. But the differences are not only in terms of prevalence of disease, there are also differences in terms of prognosis and disease management between races and between social classes. Blacks, for instance, have a poorer outcome from hypertension than Whites[2-4]. Further, it has been ascertained that medical care is less accessible to Blacks than Whites[5] and this is particularly seen in the use of therapeutic procedures for coronary artery disease[6]. There are many potential explanations for these differences. Genetic make-up, life style differences, cultural up-bringing, beliefs and practices, availability and affordability of health care services are potent reasons.

The impact of sociocultural factors on this epidemiologic picture in some cases may be considerable. Otten *et al*[1] have calculated that the excess mortality of Blacks over Whites could be accounted for by conventional risk factors like hypertension in only 31% of the mortality and by family income in 38% of the mortality, leaving a further 31% of mortality unaccounted for. Whilst the prevalence of smoking is similar between Blacks and Whites, and that heavy smoking is far less among Blacks, Blacks are less likely to quit the habit[7]. Japanese have a low prevalence of coronary artery disease, yet with migration to Hawaii and the West Coast of the United States, their prevalence increases progressively[8]. Interestingly, hypertension was more likely to contribute to coronary artery disease in California Japanese and to stroke in Japanese in their home country.

Early and timely diagnosis can of course make a substantial difference to the prognosis of certain diseases. Whether late or inaccurate diagnosis might contribute to some of the differences in the prevalence and manifestations of diseases between races have not been well addressed. The potential contribution of sociocultural factors to the diagnosis is exaggerated when the description of symptoms is a major basis for diagnosis. Accurate and appropriate description is essential. The patient needs be articulate and accurate enough to describe and relate to the doctor the symptoms which he experiences. The patient though can only describe what he actually experiences and not the classical description expounded in medical textbooks. The presence of different races with their respective different up-bringing and different languages such as the case of Malaysia provides a rich interplay of these factors for the doctors and may present a daunting task to the doctor if he or she were to strictly adhere to textbook description of symptomatology. Yet, this area of sociocultural influence on the perception of disease and symptomatology has not been adequately investigated though imminently instructive and potentially useful.

Our article in this volume of the Journal[9] highlights this issue by taking description of angina pectoris as an example. Describing pain is always difficult. But when the description is an important part of the diagnostic process, it becomes that much more important and it behoves on the doctor to pay considerable attention to what and how the patient describes. This can only be done if one knows the local words and descriptions used by patients and one may need to take a stepback from classical (Western) descriptive terms. Our study shows that while there are some similarities between the terms used locally and that of the textbooks, some important differences are obvious. Some descriptive terms used locally for angina might have suggested causes other than angina for the chest pain if these were used by the Western population. Further, our patients tend to use more than one descriptive term to describe a similar event (angina) and that these terms tend to be used

interchangeably. Whether these findings are only true for the locality (Kuala Terengganu) or the population (Malays) or the symptom (angina pectoris) studied is an open question and awaits further work. What is obvious is that literal translation into English and studious reliance on textbook description of disease and symptomatology may not only be inaccurate but potentially misleading.

Yet, even if the diagnosis is certain or a working diagnosis has been formulated by the attending doctor, sociocultural factors continue to exert its influence - this often have considerable impact on the outcome of the patient. Through ignorance, fear, prejudices, poverty or contending 'traditional medicine' practices, patients may refuse medical advice. This advice may be in terms of treatment, investigations or changes in life-style. Deng, Aziz and Zulkifli[10] in this volume of the *Journal* highlights a common problem faced by paediatricians in the country where consent for lumbar puncture for febrile children is often refused by parents. In their study, lumbar puncture was refused by parents of 8 of 28 children whom lumbar puncture was sought. They identified that Malays or female child as factors more likely associated with refusal of consent. Parental education and socioeconomic status, belief in traditional medicine and history of lumbar punctures in siblings did not tend to influence parental consent.

Sources of information which were influential in the parental decision were especially friends and relatives, and much less influential were the mass media and medical personnel. But it is less likely that the latter two were *not* influential but rather might have been less made use of. Perhaps, with greater use of the mass media by medical personnel to educate the public on this issue, not only the parents would be better informed but so would the 'friends and relatives'. The abysmal contribution of formal education and socioeconomic status in influencing appropriate health behaviour in Malaysia had also been seen in another context previously[11-12]. This disconsonance between being literate and adopting and choosing appropriate health behaviour is disconcerting and need further thorough study and evaluation. In the meantime, realising these important sociocultural influences on disease perception, the medical profession need to take a more active role in educating the patient and the public and also in combating negative inputs like promotion of unwarranted traditional beliefs and practices detrimental to health like smoking.

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