Organizational v.s. The Individual

With the myriad of advancements made in biomedical anthropology and in medical technology, the milieu in which medicine is practiced has not yet made that leap. The main issue resides in the organizational regulations and norms interfering with the delivery of medical care that truly encompasses the notion of caring, humane, ethical, and attuned to the experience and needs of a typical patient. Some of the most pressing limitations placed on medicinal practice include cultural influences as well as institutional administrations in settings such as the military, specifically for those seeking therapy or physiological help in the army. This resides along the lines of being fostering a more culturally cognizant community and respecting the cultural wishes of a patient in accordance with respecting the diagnosis of a doctor or therapist to perpetuate an ethical and moral treatment plan that the patient feels comfortable with. Some realistic changes that can and should be implemented include restructuring the system of power in a military environment, where a therapist has the final say over what a soldier is capable of enduring or the actions they should take in the future. In a cultural setting, doctors and hospitals should be educated on local cultures and ideologies to better create a supportive environment where the patient feels comfortable.

In terms of cultural standing, Sahli’s article focuses on the preventative techniques used in medicine, pertaining to the ethnomedical systems. The author explains how this is an extrapolation of the material culture of our own creation. “Embracing the ritual, or ‘mystical.’ aspects of clinical medicine diminishes neither its validity nor the efficacy of the scientific approach” (Sahli, 205). Sahli continues to convey that the ritualistic aspects of clinical medicine do not belittle the advancements made by modern North Americal medicine. Instead, these symbols and rites are an integral part of medicinal practice. For example, Taking an oath to affirm the notion of professionalism and ethical practice in medicine. This way graduating medical students are made to understand a certain decorum while treating patients and the importance of their jobs. While rituals may not be percieved as a vital part of medical practice, they are symbolic and used to inspire faith and trust between patient and doctor, important in a patient’s convalescence. If the patient believes in the treatment being offered to them, even in many of the rituals, they will be more likely to accept the treatment/medicine. They will go along with the doctor’s treatment, instead of rejecting it, inadvertently helping along their healing process. “Symbols help the healer to believe in her own powers while at the same time to enhance the beliefs of the patients and his social group” (Sahli, 204). As can be seen, although certain medical rituals may not seem to have a strong medical backing, their benefit to a patient’s mental and emotional state seems to be a valuable asset.

Both articles explain that the unified majority in western countries tend to view medical advancement as purely scientific and exclusive of any cultural ideology. The idea of culture in the medicinal field of study is instilled in non-western medical systems, as explained by both articles. An example in the Lupton writing is that in many Asian and African cultures, many illnesses are categorized as “hot-cold”, meaning that they are caused by imbalances of “hot“ or “cold” in the body. For example, Lupton describes “culture-bound syndromes” to illustrate a cluster of symptoms that seem to be particular to a specific culture and not recognized in other cultures. He describes a phenomenon known as the attack of the nerves, involving behaviors such as uncontrollable shouting, crying, fainting, or aggression. This condition is recognized as an illness mainly by Spanish speakers in the Caribbean and Latin America. Cultural practices do not need to necessarily be enforced by medical practiconers, but they should be understood and respected. “The concept of [“cultural competence”](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831630/) is now commonly used in the medical literature. It highlights the importance of doctors and other health professionals understanding that their patients from another culture that may hold different beliefs about illness and may experience poorer quality health care as a result of communication breakdowns” (Lupton, 1). Hospitals should be educated on local cultures and be accepting of them, even if their opinions on the matter differ. This way, doctors can better understand and connect with their patients and provide them with better care.

A western cultural ideal, as Lupton explains, is a symbol of efficiency and hygiene. This is similar to the oath taken by graduating medical students in Sahli’s article. Despite objective scientific principles underscoring western medicine, there is still a myriad of cultural beliefs and practices developed by living in western culture. The problem is that this cultural norm has been taken too far. Stillo furthers this point by elaborating upon his experience doing research in a mountaintop tuberculosis treatment center in Romania. Patients are so desprate for and deprived of human interaction, as they experience very little in their daily lives. Stillo’s experience exemplifies the horrifc inadequacies of doctors, as they never took the time to get to know their patients. “ He told me that doctors never sit on patient’s beds and they never ask about things like this” (2) in regards to questions about his interests and loved ones. It is shocking and appauling that Stillo had been the only one to sit beside Mr. Gheorghe and many of the other patients. Doctors should see patients for who they are: their experiences and their family, instead of just an illness. “[Patients] wanted someone that they trusted to tell them it was ok” (Stillo, 1). This should be the joba of doctors as caretakers. Doctors should see beyond the statistics and data charts. They should take a more personal interest in their patients to really understand their struggles, that way the patients feel better cared for and the doctor can take better care of the patients. In addition, this engenders a more welcoming and supportive milieu for patients, doctors, and visitors alike. This ideology should be mandated and enforced in any and all medical practices and clinics.

Norms are informal understandings that govern the [behavior](https://www.basicknowledge101.com/subjects/mentalhealth.html#behavior) of members of a [society](https://www.basicknowledge101.com/subjects/sociallearning.html). They encompass rules that guide beahvior in certain situations or environments. Many times, specifically in the field of biomedicine, the opinons of medical professionals are overruled by their superiors’. For example, Military Mental Health-Care is marked by the conflict between caring about the welfare of individual service members and the medical corps’ mission to “conserve the fighting strength”. “Medical anthropology has played a crucial role in illuminating the often vast gulfs between formal discourses of professional ethics and ‘what really matters to people in local contexts’” (Lessing, 2). To elucidate this point, essentially medial corps aims to keep trained soldiers in the field for as long as possible, as they had already invested so many resources training and deploying them. Unfortunately, this does not bode well for the soldiers, as their mental illness is not taken seriously. Unlike a physical illness, where the extent of the injury can be observed, mental illnesses cannot. Often times this means they are overlooked even though they have the potential to be just as debilitating as a serious physical injury. As a result, many soldiers or patients continue to be deployed and never fully recover from a mental illness or the trauma they face. Medical anthropology has been used to shed light on the crucial balance between formal discussions of professional ethics and what regulations should be applied and a real-world context.

What is bothersome is that Dan was not the only one facing such uneasy circumstances. The choices he was forced to make and the situations he was put in did not fit within the realm of “professional-ethical conflicts”. Dan did not question what he should do in this situation or what choice he should make. Instead, he faced the question of whether he is structurally prevented from doing what he thinks should be done and whether he can live with the choice he has made. “This is a prime example of the often discordant metrics of success and failure that military clinicians have to grapple with: for the commander (and the military organization more generally) the measure of successful treatment is not ‘health’ or ‘well-being,’ but the ability to do one’s assigned job. A fully-functioning soldier simply did not meet the criteria for a medical evacuation – at least not at that particular time and place” (Lessing, 3). In the future, the council of a medical professional should be taken seriously. More specifically, the diagnosis of mental illness should be taken more seriously, regardless of the patient’s outward appearance. We must destigmatize the idea of mental illness and prioritized the patient’s or soldier’s mental well-being over anything. Doing so requires us to understand that counselors are well trained and their expertise should be respected and their diagnosis followed.

A patient’s perception of their prognosis, treatment, and care can be shapped by any one of their experiences. Anspach and Beeson explain that emotion is connected to both our medical and moral lives. “Both Medical life and moral life evoke deep emotions. Merely contemplating a hospital conjures emotion-laden images” (Anspach and Beeson, 112). For example, when a person thinks of a hospital, no matter the situation, they think of some sort of imagery. An instance of this would be someone thinking of a hospital and remembering the nights spent visiting a loved one with a terminal illness. This imagery is then related to emotion. The memory of visiting a loved family member or friend may engender a sense of fear, grief, or apoplectic anger within that person. On the other hand, someone may remember a hospital and remember their child being born, sparking joy within them. These moments and experiences are the underlying factors for the judgments we make on a daily bases. By this logic, if doctors are more compassionate and understanding, they will make a greater positiver influence on the patient. The patient in turn will have an easier time dealing with their prognosis. They will not associate negative emotions or feeling is the hospital or doctors and will more likley accept their treatment now and in teh future. Our experiences and perspectives on different facets of our medical and moral lives are what shape our future actions and perspectives.

Compassion is considered an essential element in quality patient care. Understanding patients’ perspectives is important and can guide practice, policy reform, and future research.

One of the most powerful methods to promote ethics in health care is to role model ethical performance on the managerial level, specifically in a hospital. This style of leadership involves the development of appropriate normal behavior through personal actions and interpersonal interactions, and also promotion of such behaviors in subordinates through bilateral exchanges and strengthening of decision-making. Ethical leaders (such as the managerial system at hospitals) must strive to model and support ethical performance and at the same time be sensitive to moral issues and enhance doctor's performance by fostering respect for human dignity; thus, they can play an important role in promoting patient safety, increase the capacity to discuss and act upon ethics in daily activities, and support the ethical competence of doctors. These behaviors include empowering patients to express their concerns and worries, and providing recommendations for improving their work environment and patient care.