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# Calling Dr. Diet, Dr. Quiet and Dr. Merryman

How to address cultural conceptions of illness, health and wellness

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snapshot

The author explores factors in several countries that affect patients' and doctors' approaches to health and medicine and their implications for global health care marketing research.

Marketing researchers recognize that emerging markets will provide the engine of pharmaceutical revenue and profit growth in the coming decades. Because global markets vary dramatically in how consumers view illness, health and wellness (e.g., what illnesses mean, the remedies available, the best sources of advice, the best ways of treating), effective health marketing requires a deep understanding of local mind-sets. Fortunately, medical anthropology can inform global pharmaceutical marketing research studies by providing a deep understanding of local ethnophysiology (culturally-embedded beliefs about how the body works), cultural disease categories, beliefs about causes and vulnerability and beliefs about the interplay of Western medicines with traditional/herbal medicines.

Based on research conducted in a mix of established and emerging countries, we identified a set of

seven global truths and implications for global health care-focused marketing research:

### 1. Biological and medical concepts are converging

Global communication is standardizing disease categories and treatment concepts, particularly among urban, educated classes and physicians, many of whom are trained in the West. Pharmaceutical advertising and government-sponsored PSAs also drive standardization of concepts through widely available media and growing global Internet penetration. This convergence makes global pharmaceutical marketing research possible as it provides a baseline level of thinking about health.

### 2. Western medicine is being integrated into treatment regimens

Although traditional herbal approaches are generally preferred for minor ailments and prevention, Western medicine now plays a role in health care nearly everywhere, alongside traditional beliefs and practices. Western medications are commonly viewed as “strong,” i.e., effective but prone to side effects; therefore, these medications tend to be viewed as most appropriate for “serious diseases.” In many markets, physicians tend to view branded products as superior in avoiding side effects, yet side effects are often viewed by patients as a sign of efficacy, as suggested by the Swahili saying, “Bitter pills may have blessed effects.”

From a research perspective, Western medicines are expected to be strong and effective (garnering high brand ratings on such attributes) but items assessing “too strong” and “interferes with the body’s natural processes” may be just as important, as is the potential for mitigating side effects with traditional/natural remedies.

### 3. Skepticism reigns

Patients around the world share skepticism about doctors and medicine, as indicated by folk sayings such as “The best doctors are Dr. Diet, Dr. Quiet and Dr. Merryman” (China) and “A good laugh and a long sleep are

the best cures in the doctor’s book” (Ireland). Questioning should acknowledge that consumers generally try to avoid treating by use of more extreme phrasing to find differences among consumers, e.g., “I wait as long as physically possible before taking medicine.”

### 4. Prevention is better than cure

In many cultures, folk wisdom extols the virtues of disease prevention, as conveyed by the proverb “A man too busy to take care of his health is like a mechanic too busy to take care of his tools” (Spain). Disease prevention is typically equated with healthier lifestyles (i.e., improved diet, exercise and smoking cessation), with the key demographic of urban, educated, upper-class females age 18-35 representing heavy adopters of natural products, herbal teas, vegan diets, alternative meds, yoga, Pilates and avoidance of artificial ingredients. This desire for healthy lifestyles can be taken to extremes, as in a new condition known as *vigorexia* (exercise mania) afflicting young urbanites in Spain. Conversely, emphasis on improved diet can be a reaction to the loss of indigenous cuisine and corresponding rising rates of obesity. For example, Italy, Southern France and Spain have always been known for the heart-healthy traditional Mediterranean diet of fresh fish, fruits and vegetables, pasta, olive oil and garlic, yet due to the proliferation of processed foods and fast-food outlets, Italy now has a childhood obesity rate of 25 percent.

When designing research, questioning needs to raise the bar on healthy lifestyle attitudes in order to find differences among consumers since there is near universal agreement that diet and exercise are good for you. More extreme statements can effectively differentiate consumers, e.g., “I follow a very strict diet” or “I am diligent about getting physical exercise regularly.”

### 5. Illness is a family thing

In most cultures, illness is viewed as a disruption to the total family system. In addition to the financial impact associated with the loss of the patient’s income and the loss of care-

giver income, there is the emotional impact and physical stress of caregiving. In virtually all cultures, the family constitutes the major source of caregiving in response to the needs of the ill or elderly. When designing research for chronic conditions, it is often useful to include a sample of caregivers as an important source of influence on treatment, a window on patient status and to measure the indirect impact of the disease on others.

### 6. Mental illness can carry stigmas

In virtually all cultures, mental illness carries significant stigma, which is expressed in culture-specific ways. In individualistic cultures, the foremost threat is to one’s identity, leading to feelings of shame, especially for men. Spain and Italy, the global hubs of machismo, share the lowest rate of seeking help for mental health problems, especially among men. In communalistic cultures, such as China and Japan, the primary threat is to one’s (and one’s family’s) standing in the community. Because of the broader risk, mental illness is generally hidden as long as possible and doctors tend to label mental health conditions with remarkable vagueness: a very common diagnosis in China is neurasthenia (*shenjing shuaijo*), a diagnostic code that was abandoned by Western psychiatry 50 years ago. *Shenjing shuaijo* can include any of the following: anxiety, depression, bipolar disorder, sexual dysfunction, anemia, insomnia, attention deficit disorder, etc.; the ambiguity of this diagnosis serves an important protective function.

Similarly, in Central and South America, mental illnesses are often treated as spiritual crises that go by various names (e.g., *espanto* (“shock”), *susto* (“fright disease”), *mal de ojo* (“evil eye sickness”). Traditional healers called *curanderos* use religious rituals, ceremonial cleansing and prayers as treatments, which takes mental illness out of the realm of medicine and into the realm of religion, thereby preserving the self-esteem and social standing of the afflicted. In the West, too, there is a strong preference for treatment by general practitioners,

psychologists or neurologists instead of psychiatrists, which tends to be stigmatized as appropriate for the most severe cases.

When conducting research on mental health conditions it is important to convey the procedures that ensure anonymity and confidentiality to reassure potential respondents. Additionally, in cultures that tend to categorize mental illness in different ways, symptom lists can be combined to identify conditions so that patients do not need to admit to the stigmatized condition directly.

## 7. Dermatological conditions can carry stigmas

In virtually all cultures, skin disorders carry significant stigma because dermatological problems are visible and may be interpreted as contagious or infectious. As a visible “defect,” dermatological conditions affect marriageability in many cultures. In rural parts of Brazil, an outbreak of shingles is often treated by three days of prayer or “pranic healing.” If more than one person has a visible dermatological condition simultaneously, it is considered a sign of bad luck for the whole community. Because of the fear of stigma, sufferers typically go to great lengths to hide affected skin. Similar to mental health research and STDs, care must be taken to reassure respondents of privacy and anonymity procedures when attempting to research dermatological conditions globally.

### Sharply divergent

In contrast to the global truths, health practices can be sharply divergent between markets.

**Cultural conception of disease.** Different cultures can have vastly different ways of thinking about diseases. For example, some diseases are expected as a normal part of development (e.g., chicken pox) whereas others are unexpected (e.g., shingles). Some diseases are culturally stigmatized (e.g., STDs, lung cancer), whereas others are culturally supported (e.g., breast cancer, MS). Other cultural distinctions include minor vs. serious, acute vs. chronic, inherited vs. acquired, etc. Different cultures also can hold radically different notions about disease causa-

tion. In Western cultures, heredity, lifestyle (e.g., diet, stress) and the environment (e.g., germs, allergens) are prominent causes, yet in many parts of the world illness may be alternatively attributed to heat, cold, moisture, pollution and a host of supernatural causes including curses, possession, soul loss, etc.

The bundle of meanings attached to a disease is known as a semantic disease network; these networks matter because how disease is conceptualized determines how it’s treated, as summarized in the Spanish proverb “The beginning of health is to know the disease.” For example, in Western countries, diarrhea, skin rashes or a dry cough are recognized as distinct conditions with no clear correlation. However, in parts of Asia and Africa, the co-occurrence of these symptoms is recognized as “inside fever” – a fever that is undetectable to the touch or via thermometers and settles deep within the body. For those conducting a global research project on the GI tract, dermatological conditions, or upper respiratory conditions such as asthma or allergies, it may be important to address inside fever in questioning.

A variety of folk illnesses have been documented. *Susto* (fright sickness) and its more severe form *espanto* occurs in Central and South America, which are akin to PTSD or even schizophrenia in some cases, attributed to “soul loss” resulting from severe fright or trauma. Others include *empacho* (impacted stomach), *dhat* (semen loss anxiety) in India and Sri Lanka; *koro* (penis shrinkage delusion) in China and southeast Asia; *boufée délirante* (chronic hallucinatory psychosis) in France; *kreislaufstörungen* in Germany (i.e., dizzy, lightheaded, weak, anxious feeling attributed to poor blood circulation; akin to the Victorian British folk illness known as “the Vapors”); and bulimia nervosa and Type A behavior pattern in Western cultures. If research pertains to any of the symptoms associated with a folk illness, analysis should go beyond the individual symptoms and incorporate the cultural syndrome.

When designing research, it’s important that disease descriptions fit local understandings. Fit can be

improved by permitting multiple routes to qualification through various culturally-appropriate condition labels and through symptom lists; e.g., in China, seasonal allergies can alternately be called flower symptoms, wind pimples or allergic rhinitis. It can be important to capture culturally adjacent co-morbidities to align questioning with local understandings of conditions that naturally “go with” the condition of interest. For example, in traditional Chinese medicine, erectile dysfunction is associated with kidney problems. It also be important to include culture-specific condition triggers to capture align with local ideas regarding disease etiology. For example, in describing GI problems to southern Europeans, the notion of “eating too quickly” is relevant.

**Access to physicians.** Access to physicians is markedly different in various parts of the world, with structural factors determining the quality, quantity and duration of patient-physician interactions. For many countries with national health services, physician visits typically last a maximum of 10 minutes and may require four-hour wait times. Health care concepts need to adapt to fit radically different delivery systems, as illustrated with the following four examples:

- In China, patients tend to self-refer or are referred by nurses (not PCPs) to specialists at regional hospitals.
- In Italy, GPs play a strong gate-keeping function. In order to gain access to specialists or prescriptions, patients must build a case for referrals by exaggerating symptoms.
- In India, registered medical practitioners can be trained in either Western medicine or traditional Ayurveda, Yoga, Unani, Siddha, Homeopathy and/or Naturopathy (AYUSH). Any of these practitioners may practice as “qualified doctors” whether or not their knowledge is “supplemented by modern advances.” Although AYUSH practitioners are prohibited from prescribing Rx treatments to patients, this practice is widespread.

- In Japan, because other forms of health care are not reimbursed, physicians have a monopoly on health care delivery including the ability to directly dispense medication to their own patients.

In each market, researchers need to have a firm understanding of what constitutes a doctor, with which type of health care professional patients have relationships, the presence of primary care physicians, gatekeeping functions, etc.

#### **Access to pharmaceuticals.**

Similar to physician access, access to pharmaceuticals is highly variable and the structure of delivery systems determines pharmaceutical usage. Prescriptions are not required in many emerging markets, such as China, Mexico, Brazil and India. Western notions of pharmaceutical access must also adapt to fit different delivery systems when conducting research. This is illustrated with the following three examples:

- In India, patients are more likely to have a personal relationship with their local pharmacist than with a physician. Local pharmacists (chemists) make diagnoses and directly dispense medications.
- In Brazil, pharmacists are sometimes paid commissions by local manufacturers of generics to prescribe these over branded medications.
- In China, government cost-cutting has reduced physician reimbursements, motivating physicians to supplement their incomes by receiving commissions to prescribe certain drugs, with heavy reliance on drugs that are stocked within the physician's hospital pharmacy.

When conducting research in these markets it can be more important to discuss pharmacist relationships than to ask about doctor relationships and to be aware of the potential for conflicts of interest.

#### **Beliefs about Western medicine.**

Western medicine's perceived strength is viewed in many cultures as disruptive of the body's natural

balance. Consequently, it tends to be viewed as too strong for patients in states of weakness such as childhood, pregnancy and old age. The strength of Western medications is believed to cause habituation, such that larger doses of Western medication are needed over time to get the same effect. Alternately, Western medicines are viewed as artificial and "industrial" and their use changes the body such that traditional remedies no longer work; for example, in India there is a common notion that overuse of Western medicines makes the body "hot" – akin to overuse of fertilizers and pesticides in soil.

The physical characteristics of medications (form, color, taste, shape, pill size, etc.) can have surprisingly important connotations to patients in different markets. In India, white pills are considered mild and safe, whereas black pills are considered powerful and dangerous, which can affect patient compliance. Depending on the market, it can be very important to obtain consumer feedback on the physical characteristics of medications and the connotations of each.

#### **Role of traditional treatments.**

In many regions, traditional herbal medicines tend to be preferred for health maintenance and disease prevention similar to the vitamin and supplements market in the U.S., as a first-line treatment, especially for milder ailments, to prepare the body for Western medicines or to restore the body after treatment, to boost the effectiveness of Western medicines and to mitigate side effects of Western medicines. In China, physicians receive training in traditional Chinese medicine in medical school and some doctors practice traditional Chinese medicine alongside Western medicine. Similarly, Mexican physicians prescribe traditional herbal medicines alongside prescription medicines as means to control negative side effects.

When conducting research in emerging markets it is important to resist the temptation to apply a Western lens in classifying patients as "pro-medication" or "anti-medication." In many countries, this dichotomy does not hold because nearly all patients accept both Western medica-

tions and traditional remedies; more useful distinctions can be drawn in ways that traditional remedies are used in conjunction with medications.

**Lifestyle change.** Despite government-sponsored attempts to promote a variety of healthy behaviors, culture-based traditions associated with alcohol consumption, driving under the influence, smoking, over-eating, lack of exercise, driving at high speed, failure to wear seat belts and/or drug use conspire to create barriers to behavior change. Culture-based resistance to lifestyle change is powerful in certain markets, as evidence by the Mexican saying "Graveyards are full of people that are too clean."

When conducting research, it can be important to measure not just attitudes that reflect aspirations to live a healthier lifestyle but to also include measures of social norms regarding lifestyle change. Measuring cultural barriers to lifestyle change should always include "permission statements," i.e., statements that suggest that such attitudes are widely held and perfectly understandable (e.g., "Like most people, I think you have to live for today and not worry about the future").

**Skepticism of doctors.** Doubting the skill and motives of physicians is a widespread and ancient tradition, as evidenced by the Chinese proverb "A young doctor makes a full graveyard." Unfortunately, there is sometimes more than a kernel of truth to these observations. In India's two-tiered system of private vs. public physicians/hospitals, the quality of care is markedly different. World Bank researchers studied public doctors' treatment of five common conditions and concluded that patients stand a 50-50 chance of receiving a harmful treatment. Corruption is also endemic: one-third of patients in government hospitals claimed that they had to pay bribes or use influence to get faster access to treatments or appointments with more experienced doctors and to get clean sheets and better food. Unsurprisingly, the Indian upper classes avoid public doctors and hospitals. These dramatic cases of poor quality associated with free or subsidized health care recall the African proverb "If you are too smart to pay the doctor, you

had better be too smart to get ill.” An implication for research design is that it may be important to measure perceptions of trust and quality associated with different tiers of health care professionals.

Cultivating confidence among patients is critical to the success of doctors, particularly in rural areas. In rural India, successful doctors are those who gain a reputation of having the “power of the (healing) hand.” Similarly, in Mexico, the term *confianza* as applied to the relationship between patient and doctor goes beyond the literal translation of “confidence” to imply a deep and abiding trust and respect. Because reputation is critically important to the commercial viability of small practices, to mitigate this risk, doctors in some emerging markets actively seek to protect their reputations through a variety of means including “softening” diagnoses (providing patients with diagnostic labels that are inaccurate but more acceptable) and/or “softening” treatment (providing patients with treatment regimens that are less efficacious but more acceptable or affordable). Doctors in these markets fear that by immediately diagnosing the full extent of serious conditions or by prescribing uncomfortable or expensive treatments, patients will simply go elsewhere and will tell others of their experience, diminishing their reputation for healing ability. Some doctors may consider these practices to be less self-serving and more of an attempt to minimize patient fear and social disruption.

There are many examples of diagnostic softening: In south India, cholera and dysentery are often labeled as gastroenteritis. In the Philippines,

tuberculosis is often labeled “weak lungs.” Even “lung cancer” among Vietnamese may be a preferred label to avoid the stigma and social isolation associated with contagious tuberculosis. In addition to mislabeling of health conditions, asymptomatic stages of serious illnesses may be downplayed to patients.

Social and economic factors also play into diagnosis and treatment in many regions. Diagnosing the patient’s ability to pay is an important part of medical practice in rural and emerging markets. Where patients are deemed to be unable to afford proper treatment, expensive medications may be delayed.

When conducting research in these markets, it can be important to use permission phrasing when asking doctors about diagnosis and prescribing to address issues around tendency to soften diagnosis and prescribe suboptimal but affordable treatments. For example, we might wish to ask physicians to what extent they agree that “Maintaining a patient’s sense of hope is ultimately more important than making them accept a difficult diagnosis” or “Doctors need to consider patients’ ability to pay for treatments when making recommendations.”


### Create clear challenges

There are many significant cross-cultural differences in the worldview of both patients and physicians that create clear challenges to cross-cultural marketing and research. These challenges may be summarized by posing a set of questions that marketing researchers might ask themselves as they design cross-cultural studies.

**Disease.** Are there local, in-country experts on the research team repre-

senting each major region, ethnicity and language? Is cognitive pre-testing of all research instruments conducted in all local languages and dialects? For any stigmatized conditions under study (e.g., mental health, dermatological conditions, etc.), is the data collection method discreet, with anonymity procedures explained to participants? Does the local semantic disease network guide disease language, including both formal and colloquial names for diseases of interest, as well as folk illness syndromes? Are symptom lists provided for non-self-identified sufferers? Are culturally-adjacent co-morbidities included?

**Health care provider.** Is questioning appropriate to local HCP-patient relationships? Is the local pharmaceutical distribution system accurately reflected (e.g., directly dispensed by physician, dispensed by pharmacist without prescription, written to hospital pharmacy, retail pharmacy, etc.)? Is permission-language for physicians included for sensitive subjects (e.g., preserving a patient’s position in their family and community is more important than the pace of recovery)?

**Treatment.** Are culturally-relevant treatment attributes included (e.g., Can be used even in states of weakness)? Is the prescription vs. non-prescription distinction locally relevant? Is the branded vs. generic distinction locally relevant? Are local side effect concepts included (e.g., heat, bloodlessness)? Are physical characteristics of treatment included? Are local treatments included? 

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