

## CULTURAL HEALTH BELIEFS IN A RURAL FAMILY PRACTICE: A MALAYSIAN PERSPECTIVE.

Understanding the socio-cultural dimension of a patient's health beliefs is critical to a successful clinical encounter. Malaysians, comprising a multi-ethnic population of Malays, Chinese and Indians still use a wide variety of traditional healthcare systems in spite of having a remarkable modern rural health service. Patients' perceptions of health, expectations of healthcare, treatment choices, advances in health care, and other aspects of care are influenced by class, culture and religion. Clinicians may be inadequately trained to face the challenges of providing quality care to socially and culturally diverse populations.

This paper highlights some of the health beliefs, perceptions and practices relating to a variety of common illnesses encountered in the authors' rural practices. Some aspects of traditional healthcare are discussed in an attempt to explain these health beliefs and practices, in the context of the traditional worldview of the patient and scientific viewpoint. Issues discussed include traditional practices of 'hot and cold' notions of 'Yin-Yang' and the Ayurveda system, how the mystery and speculation of the inner structure of the body influences people's perception and presentation of body symptoms and why somatisation is common among Asians. 'Health precautions' taken by women during their menstrual periods and taboos about diet, dress and behaviour during pregnancy and childbirth that marks the transition of a social status of woman to that of a 'mother' are discussed. The authors attempt to

address and explain the following questions. What is their approach to truth telling, collusion and advanced directives when dealing with their loved ones with terminal illness? How is death anxiety related to their cultural beliefs? How does cultural healing help patients with neurotic disorders, psycho-physiological problems and somatised syndromes? When and why do patients turn to alternative medicine?

Modern and traditional medical systems are potentially complementary rather than antagonistic to each other. Understanding the different cultural background and traditional practice of patients will help to promote better communication and cooperation between doctors and patients, improves clinical diagnosis and management, avoid cultural blind spots and unnecessary medical testing and lead to better compliance of patients with treatment. It is hoped that ethnic and cultural considerations can be integrated further into the medical curriculum and modern health delivery system to improve care and health outcomes.

Ariff KM, Beng KS. Cultural health beliefs in a rural family practice: A Malaysian perspective. *Aust J Rural Health*. 2006 Feb;14(1):2-8 [PubMed] [Editor's note: The citation of this article is as in PubMed.]

Reprints request: Dr Khoo Siew Beng, Department of Family Medicine, Penang medical College, No 4, Sepoy Lines Road, Penang 10450, Malaysia. E-mail: sbkhoo@pmc.edu.my

## ANTIBIOTIC PRESCRIBING IN PRIMARY CARE

A survey of urban general practice consultations revealed overall antibiotic prescribing rate of 33.1%.<sup>1</sup> In contrast, the overall antibiotic prescribing rate in a large public primary care clinic (Klinik Kesihatan Seremban) was 16%.<sup>2</sup> The antibiotic prescribing rates for upper respiratory tract infection (URTI) for the general practice and public primary care clinics were 68.4% and 26%, respectively. The commonest antibiotics prescribed for URTI were amoxycillin (in general practice) and erythromycin (in public primary care clinic). The use of penicillin V was rare in both settings.

While there may be bones to be picked in the methodology of both surveys, these studies suggest overuse of antibiotics in Malaysian primary care setting, in particular for URTI - an infection that is primarily viral in origin. Narrow-spectrum antibiotic (penicillin V) is not favoured by the primary care doctors. The use of broad-spectrum antibiotics (such as erythromycin and amoxycillin) is less

appropriate as they are more closely linked to the emergence of antibiotic resistance.

As we decry the suboptimal prescribing practice, we are fully aware of the pressure faced by the frontline physicians in busy clinics - it is always easier to prescribe the antibiotics rather than spending precious time dissuading the demanding patients. Perhaps we need to focus more on effective symptomatic relief.

1. Teng CL, Leong KC, Aljunid SM, Cheah M. Antibiotic prescription in upper respiratory tract infections. *Asia-Pacific Family Medicine*. 2004;3(1,2) [Full text]
2. Teng CL, Achike FI, Phua KL, et al. General and URTI-specific antibiotic prescription rates in a Malaysian primary care setting. *Int J Antimicrob Agents*. 2004 Nov;24(5):496-501 [PubMed]

Reprints request: Assoc Prof CL Teng, Department of Family Medicine, IMU Clinical School, International Medical University, 70300 Seremban. Email: tengcl@gmail.com