

# Cultural Encounters and Family Medicine: Six Lessons From South America

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Our lives are filled with lessons. Each of us takes from our encounters with family and friends and patients deeper understandings with which we can make sense of the complexities of our personal and professional lives. These understandings enrich us all.

I present here six lessons I learned during my tenure in 1994 as a visiting professor and senior Fulbright Scholar in the Family Medicine Residency Program at the National Experimental University of Táchira in San Cristóbal, Venezuela (Figure 1). My work there was focused on teaching residents, including directly supervising their ambulatory practices, developing Balint groups, and teaching about qualitative and quantitative research methods. I spent most of my time, however, exposed to new sights, smells, sounds, and distinct ways of handling daily life, making personal discoveries all along the way.

I was a gringo in San Cristóbal, a city of 500,000 people in the low Andes Mountains. It is a commercial center located near the Colombian border, a tortuous 15-hour bus ride from Caracas, the nation's capital. As are many Latin American hubs, San Cristóbal is home to wealth and poverty, to big business and household industry. Founded early during the Spanish conquest, regionally isolated, now ever-growing in size, it has one foot in the past and one in the future. For the medical connoisseur of pathology, the city offers a wide variety of readily observed diagnoses, from anxiety to pertussis to scleroderma, and more.

In San Cristóbal I was learning a new Spanish

dialect, learning new ways to negotiate traffic in a city of hills reminiscent of San Francisco with drivers as intimidating as any cabbie in Boston, and learning ways to eat strangely exotic foreign foods and smile at the same time.

Every time I tried to understand Venezuelan life, I found myself looking at my own questioning countenance. Through this perspective, focused around the environment of my work, I learned better my role as a family physician. The lessons that follow are thus reflections about family medicine. They are, I trust, important for myself, for family physicians whether in Venezuela or in the United States, and for those who believe in the development of a reasonable system of primary care medicine around the world.

## **Recognizing Community**

I had heard much about communities and medical practice in the United States, much about community-oriented primary care. It was in Venezuela, however, where I really learned the lesson that the communities in which we practice are vitally important. There lip service became practice as I watched family physicians reach out beyond the office to understand and influence the health-related behaviors of patients.

I saw many examples of community work by the family physicians of San Cristóbal. The residency had an extensive curriculum in community medicine with an emphasis on understanding the demography of the region contiguous to the Family Medicine Center. In addition, there were two exemplary programs that I found exciting.

In the first program family physicians, both residents and community practitioners, coordinated and produced a radio program about basic health issues directed toward local farmers. The themes of this program included water sanitation and the prevention, management, and treatment of simple wounds. In each broadcast the family

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physician moderators tried to improve the community consciousness about these themes and promote an organized and active public response.

In the second program a senior resident worked in conjunction with the state chapter of the Venezuelan Society of Family Medicine to publish a series of articles in the regional paper. While the majority of these articles focused on the management of common medical problems, others were dedicated to increasing the community knowledge of and interest in the newly introduced discipline of family medicine. Titles of the articles included “What is Primary Care Medicine?” and “Family Medicine Around the World.”

I relate these efforts because they had an invigorating effect among the family physicians in Venezuela. This effect increased their personal recognition of their professional role as change agents in San Cristóbal. Searching for new and creative methods such as these to reach out to the community can help family physicians develop a progressive vision of the discipline, one that addresses aspects of community health issues that other specialties have ignored.

### Developing Sustainability

Six months into my stay in Venezuela, my bank collapsed, and I lost several thousand dollars. Unfortunately, the economic crisis in Venezuela continues. Although I am not an economist, it is clear to me that petroleum and the petroleum economy played a principal part in this disaster.

Because of oil, Venezuela was until recently the wealthiest country in Latin America. Today it is but one of many countries south of the US border struggling to stay afloat. Why? As one Venezuelan put it to me: “Oil is our friend and our enemy. It has nourished us. It will destroy us.” Owing to the largesse brought by the emergence of oil as a profitable export, the country lagged in developing a diversified industrial base. Oil became essentially Venezuela’s sole product. This dependency and the collapse of the international petroleum market became nails in the coffin of the Venezuelan economy.

Metaphorically family medicine exists in a similar world. Since World War II the model of superspecialization and an all-encompassing emphasis on the power of high technology have dominated medical training, practice, and research in the United States. Whereas the World

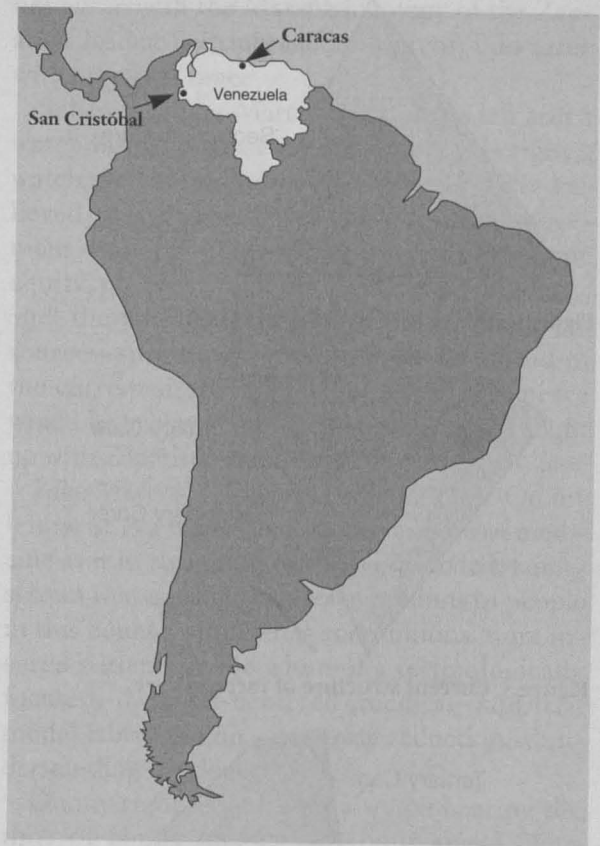


Figure 1. Map of South America and Venezuela.

Health Organization and other international public health advisory bodies promote a systemic solution to medical care as demonstrated in the so-called “pyramid of health care” (Figure 2), the current medical care structure is better pictured in Figure 3. In this inverted pyramid, the subspecialties and their monoproduct—high technology—pretend to support the system.

What is going to happen? I can’t see into the future, but perhaps the recent economic history of Venezuela can serve as an example. Without reasonable changes based upon the development and appreciation of primary care and family medicine, the current system of medicine will topple (Figure 4).

The lesson: family medicine is the foundation of a sustainable development in medicine. Sustainability comes as we recognize the fallacy of technology as a panacea for all human ills. The widely held view of progress as an unlimited expansion of high technology will doom us.

The North American economist Herman Daly,<sup>1</sup> in comparing a sustainable, steady-state



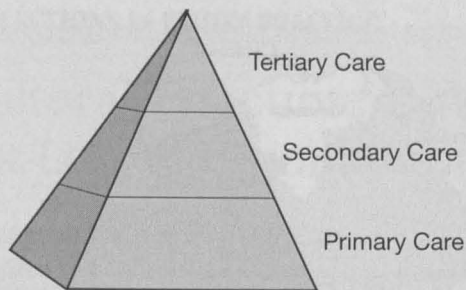


Figure 2. Pyramid of appropriate health care.

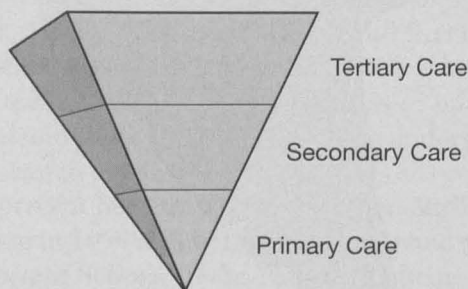


Figure 3. Current structure of medical care.

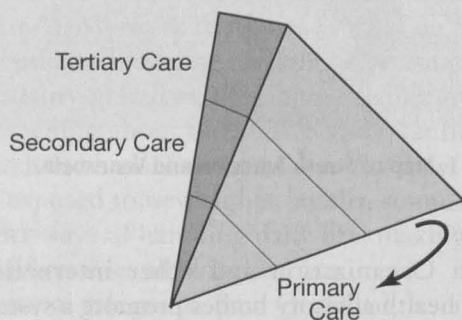


Figure 4. The future of medical care?

economy with the growth economy many find overly seductive, has written:

The steady-state economy respects impossibilities and does not foolishly squander resources in vain efforts to overcome them. Our present institutions allow technology to be autonomous and force man to play the accommodating role. The steady-state economy seeks to change institutions in such a way that people become autonomous and technology is not abandoned, but is demoted to its proper accommodating role. Growth economics gave technology free rein. Steady-state economics channels technical progress in the socially benign directions of small scale, decentralization, increased durability of products, and increased long-run efficiency in the use of scarce resources.

Daly's words ring true for those in medicine, too. Is anybody listening?

### Appreciating Sensitivity

When I first began to consider the third lesson, I framed it as an issue of sex-based traits. I thought the future of family medicine is in feminine hands. That was an easy lesson to ponder in Venezuela, where the great majority of family physicians, almost 75 percent, are women and where the word for hands, the Spanish *manos*, is deceptively feminine.

Then I looked at my own hands. While I do not think of them as *muy machos*, neither would I call them feminine. Mine are sensitive hands.

The future of family medicine is in sensitive hands, utilizing the traits of compassion, nurturance, and patience, emphasizing process not product.

As family physicians we use the basic sciences to explain to cancer-ridden patients their condition, but we do it with compassion. As family physicians we teach young mothers of newborns about common conditions, such as diarrhea and colic and the normal development of their babies, but we do it at the same time nurturing both mother and child, as well as the father when he is present. And we invite his presence. As family physicians we prescribe the most advanced medicines for those with problematic chronic illnesses, but we do it patiently, understanding the inherent difficulties and pressures of today's world. As family physicians we deal with patients and families looking at death, but we do it with a focus on death's meaning in the cycle of life.

Compassion, nurturance, patience, process. Characteristics of sensitive people. Characteristics of family physicians.

### Fostering Love

Love is of vital importance in family medicine.

Love in this context is neither the crude love of soap operas nor the exploits of the stereotypical Latin lover. Nor is it the sophisticated, artistic love so well described in Pablo Neruda's poem, "Leaning into the Afternoons"<sup>2</sup>:

Leaning into the afternoons I fling my sad nets  
to that sea that beats on your marine eyes.

The birds of night peck at the first stars  
that flash like my soul when I love you.

From *Twenty Love Poems and a Song of Despair* by Pablo Neruda, translated by W. S. Merwin. Translation copyright © 1969 by W. S. Merwin. Used by permission of Viking Penguin, a division of Penguin Books USA, Inc.

Love in family medicine is a humanistic love expressed through the profession. It is a love with physical and emotional limits, nonetheless an intimate love. It plays the fundamental role in the relationship between family physician and patient.

The Mexican author and poet, Octavio Paz,<sup>3</sup> described this type of love in his well-known book, *The Labyrinth of Solitude*: Love is “a perpetual discovery, an immersion in the waters of reality, and an unending re-creation.”

I felt this love when I left my family practice and my patients to depart for Venezuela 3 years ago. I felt this love when I returned to my practice and my patients more than 1½ years later. I felt it with the Anderson family, with whom I watched a child die, a mother lose herself to alcohol, and the remaining siblings cope with the inevitable behavioral problems. I felt it with Carlos Mendez, a roofer by trade, who at the age of 44 years came to me after suffering a massive myocardial infarction, unemployed, depressed, on multiple medications yet still hypertensive. I felt it with Carolina Madrid, whom I saw routinely, repeatedly for her multitudinous somatic complaints.

I still feel this love every time I see my patients in my office. Little by little, in visits of 10 or 15 or 30 minutes, I am exploring their waters of reality, I am listening to their histories, their perceptions, their points of view in relation to their illnesses and the issues they bring to the office. And because they are with me in my office, my patients as well are involved in a constant re-creation between us.

It is with this love, as our colleague Betsy Naumberg<sup>4</sup> from Rochester, New York, has said, “one human being, a physician, [works] with another human being, a patient, [devising] new ways to put the patient’s story together and help that person.”

### Telling Time

I began my work at the family practice residency in San Cristóbal, Venezuela, on 2 January 1994 at 8 AM. Some 31 hours earlier, natives from the depths of the Lacandon Forest in Chiapas, Mexico, members of the Zapatista National Liberation Army, revolted and overtook the city of San Cristóbal de las Casas. This event shook the Latin world and, as I understand, had a ripple effect in news services here in the United States as well as in other countries around the globe. While I do

not agree with the Marxist ideology of the Zapatista leader, Subcommander Marcos, I do agree with his use of time.

Subcommander Marcos wore on his left arm a watch bearing Mexican time and on his right a watch set 1 hour ahead, Zapatista time. He believed that the ideals of the Zapatista movement—among them some measure of economic equity, the right to a representative democracy, and the fair distribution of health care resources—positioned them temporally ahead of the current situation in Mexico, and that peace would be achieved “the day Mexican time caught up with Zapatista time.”<sup>5</sup>

Like Marcos, I now wear two watches. On my left wrist is a watch that bears the time of medicine as it is, struggling with an outmoded, failing system that continues to leave millions of people in this country uninsured and millions more insured patients at the whim of a technologically focused, hospital-centered medical-industrial model fabricated on a narrowly reductionist understanding of science.<sup>6</sup>

On my right wrist I wear a watch bearing the time of family medicine, 1 hour ahead. This watch bears the time when family physicians work with their patients collaboratively and caringly, attacking and preventing disease, overcoming disability, and facing life’s difficulties. It bears the time when these same physicians model efforts in political lobbying, community activism, and curricular reform. It bears the time when they help students understand how their future roles as family physicians can transform the future of clinical learning as it applies to patient care.

Lesson five: The time is now.

### Making Dreams Reality

I have been called a dreamer and told by one among us that we cannot expect change in medicine to result from good intentions or even public support.<sup>7</sup>

If I am a dreamer, let it be so. For without dreams I would not have been privileged to have had the opportunity to play a small part in the nascent development of family medicine in Venezuela.

If I am a dreamer, let it be so. Let me invite you to join with me to dream about a time, to visualize a time, and to work for a time when the rest of

medicine catches up to the promise offered and delivered by a family-practice-based system: a system of reasonable, rational, sustainable medical care.

If I am a dreamer, let it be so. For dreams, through the lesson of hard work, can lead to new realities.

We must work hard and from the heart. *Tenemos que luchar. Chúng ta phải tận lực và tận tâm làm việc.* But be it in English, Spanish, Vietnamese, or any other language of the globe, the message is the same, and we must continue until family medicine takes its place as the foundation of medical care here in these United States, in Venezuela as in all of Latin America, and around the world.<sup>8</sup>

I believe the late Spanish poet Antonio Machado<sup>9</sup> was speaking to us as family physicians through these words:

*Caminante, son tus huellas  
el camino, y nada más;  
caminante, no hay camino,  
se hace camino al andar.*

Traveler, the only way  
is your footsteps, there is no other.  
Traveler, there is no road,  
we must blaze the path before us.

From Antonio Machado: Selected poems, translated by Alan S. Trueblood. Copyright © 1982 by the President and Fellows of Harvard College. Reprinted by permission of Harvard University Press.

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## References

1. Daly HE. Steady-state economics: the economics of biophysical equilibrium and moral growth. San Francisco: W. H. Freeman, 1982:6-7.
2. Neruda P; Merwin WS, translator. Twenty love poems and a song of despair. New York: Penguin Books USA, 1993:16.
3. Paz O; Kemp L, translator. The labyrinth of solitude: life and thought in Mexico. New York: Grove Press, 1961:42.
4. Ventres WB, Frey JJ. Voices from family medicine: toward the 21st century. *Fam Med* 1993;25:48-53.
5. Oppenheimer A. Bordering on chaos: guerrillas, stockbrokers, politicians, and Mexico's road to prosperity. Boston: Little, Brown, 1996:65.
6. Engel GL. How much longer must medicine's science be bound by a seventeenth century world view? In: White KL. The task of medicine: dialogue at Wickenburg. Menlo Park, Calif: Henry J. Kaiser Foundation, 1988.
7. Taylor RB. Success strategies. *J Am Board Fam Pract* 1992;5:361.
8. Haq C, Ventres W, Hunt V, Mull D, Thompson R, Rivo M, et al. Where there is no family doctor: the development of family medicine around the world. *Acad Med* 1995;70:370-80.
9. Machado A; Trueblood AS, translator. Selected poems. Cambridge, Mass: Harvard University Press, 1982:146.