

# Deconstructing Biases: The West is Not Best

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## Abstract

The Western world, a mirage of wealth, power, knowledge, and competence, is often used as a measuring stick to which the rest of the world is compared. Academics interested in global health understand the need to dismantle preconceived notions of people, culture, and health in their work. However, there might be one deeply rooted bias that has not left us. As I packed my bags for a month-long immersion in rural island medicine in the Philippines, I did not realize that I was unprepared to face my implicitly held belief that “health in the West is best.”

As the world becomes increasingly globalized, medicine has recognized the need to create today’s physicians as global citizens who serve populations of all cultural backgrounds.<sup>1,2</sup> This need lends a strong interest in fostering global health education, whether that is serving marginalized populations in one’s own country or working in international initiatives.<sup>3</sup> Much of the literature in this field focuses on the subtle differences in cultural practices and ideologies of health; however, very few academics have focused on the similarities of health care across nations. Through this narrative reflection piece, I argue that this conversation has inadvertently created implicit biases that limit Western medical students from understanding the breadth of global medicine. By downplaying the commonalities of medicine worldwide, we harm the growth of global health practices. As I packed my bags for a month-long immersion in rural island medicine in the Philippines, I did not realize that I was unprepared to face my implicitly held belief that “health in the West is best.”

In my first week, I sat in a third-year community medicine class at the University of the Philippines. The professor introduced a case about JJ, a child from a rural Philippine community who delayed seeking medical care due to funds and distance, resulting in his death due to sepsis following untreated tuberculosis and pneumonia. The professor then asked the class three reasons why JJ died, unrelated to physiology. I vividly remember believing I would impress this class by presenting unique social determinants of health unheard of to the students in this Eastern medical educational institution. Ultimately, I assumed the East used a biomedical model that held little space for biopsychosocial discussions.<sup>4,5</sup> To my surprise, the students in the class eloquently discussed patient health literacy, preventative care, access to care, and the disconnect between traditional and Western medicine. I had unknowingly belittled the higher education system in a foreign country by assuming the superiority of my own, when in fact I should have realized that post secondary education, in all countries, is a means of enlightening students beyond lay ideologies by teaching critical thinking.<sup>6</sup> The intersectionality of the social determinants of health with physiological science is taught to academics, unrelated to cultural beliefs in any society.

Shifting into the clinical setting of a rural island in the Philippines, I quickly felt common ground as I heard names of diseases and conditions discussed in my first year of medical school: diabetes, hypertension, tuberculosis, COPD, HIV, etc. Yet for some reason, this familiarity took me by surprise. The field of medicine is related to the

human body, and besides a few variations, all bodies have been made biologically similar. My education had trained me to learn about the diseases of the body, so I should not have been startled that this language was familiar in a foreign country. But, I was. Somewhere along the way of traveling to a “developing country,” my brain had assumed that the premise of health would be drastically different. Yet, this thought was not spontaneous. The literature in global health practices focuses largely on the need to understand areas such as tropical medicine, or infectious diseases.<sup>1,2</sup> We tend to hone into how practices are different rather than similar. Although this is justified because the context in which disease occurs is important, it also subconsciously labels health concerns in the developing world as alien to the more “developed” Western world by not recognizing any overlap. This creates a barrier to approaching the collaboration that can occur between health practitioners in various countries.

Arriving in a rural community, I had anticipated a very basic approach to health care services due to limited resources. As I progressed through my rotation, the structure of the Rural Health Unit highlighted how influential and creative direction from local leadership can change the landscape of health. My preceptor, Dr. J, was the Municipal health officer to a jurisdiction of 20,000 people. Not only was he the singular physician to the community, he also oversaw all health services and public health programming. Having the doctor be both a front-line and administrative worker allowed for the most effective change in the municipality. I witnessed how Dr. J constantly developed his academic and analytical skills in public health through continuous online education, in order to improve health delivery. At the beginning of our rotation, Dr. J presented a comparison between the national evaluations of health services in the remote island community of Alcantra in 2011 and 2017. In 2011, the jurisdiction was marked deficient in more than 80% of categories, yet in 2017 it was deficient in only 2% of categories. This community had flourished under the direction of a creative and driven doctor, despite its remoteness. Even the most rural communities can experience immense change when their leadership excels—the exact principle I applied in my own country.

I walk away from my immersion in the Philippine rural health system with the understanding that global health is an interplay of health systems, rather than a dichotomy between the “developed” and “developing” worlds. Global health is not rooted in outlining the shortcomings of another country and comparing it to my standard of efficiency. It is amalgamating the strengths of all the innovative leaders in each country to develop novel ideas for the advancement of health on a global scale. The field of medicine is more universal than I had subconsciously allowed myself to believe. Seeing world health as more

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homogeneous rather than disparate allows us, as western learners, to use our maximal potential to contribute to international health practices in the future. It means we include knowledge gained from our own world—lens in addition to learning from others, instead of seeing the two as exclusive. I argue that to truly be a global community we need to genuinely believe that no part of the world has better mastered the art of medicine and health care, but instead approach global health from a humble standpoint of community learning.<sup>5</sup> Shifting our focus from solely comparing the differences in global health to understanding similarities can negate implicit biases on superiority that develop within Western global health education.

## References

1. Tissingh EK. Medical education, global health and travel medicine: A modern student's experience. *Travel Med Infect Dis.* 2009;7:15-8.
2. Serafin A. Developing an understanding between people: The key to global health. *Travel Med Infect Dis.* 2010;8:180-3.
3. Easter SR, Raglan GB, Little SE, Schulkin J, Robinson JN. Perspectives on global health amongst obstetrician gynecologists: A national survey. *J Int Med Res.* 2016;46:586-95.
4. Huang CD, Liao KC, Chung FT, Tseng HM, Fang JT, Lii SC, et al. Different perceptions of narrative medicine between Western and Chinese medicine students. *BMC Med Educ.* 2017 May 10;17(1):85.
5. Abedini NC, Gruppen LD, Kolars JC, Kumagai AK. Understanding the effects of short-term international service-learning trips on medical students. *Acad Med.* 2012;87:820-8.
6. Altbach PG. *Comparative higher education: Knowledge, the university, and development* Greenwich, Conn: Ablex Pub. Corp; 1998.