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Cultural Differences among Israeli Dialysis Patients and Their Role in Forming Individual Behavior

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Introduction

The relative weight of culture and of other, mainly economic, factors in explaining behavior has provided a topic of discussion since the dawn of sociology. While some researchers regard culture as being relatively insignificant, others see it as the predominant factor. The former generally view economic needs and interests as the main force driving human behavior.

In the modern state, with its heterogeneous population, questions regarding the power and significance of culture take on a pragmatic dimension when dealing with social policy.

The Israeli Context

Culture was perceived as a major driving force both by sociologists and policy makers during the initial period of statehood. Derived from the functional concept of culture as a potentially divisive or unifying factor, the prevailing perception and policy held that all citizens (but predominantly the Jews) should adopt a single cohesive culture.[1]

While discussion centered on the "melting pot," or mixture of all the cultures, in practice a single well-defined culture was selected. This was a culture characteristic of the Western world (secular, rational, technological-scientific, achievement-oriented and liberal), which was generally adopted by the established Ashkenazi[2] elite. Later, critical sociologists employing conflict theory were to view this development as a manipulative use of culture aimed at achieving economic and political dominance[3].

Now, 40–50 years on, with the melting pot concept conclusively discredited[4], researchers are posing a number of questions:

1. Is it desirable to select a single culture and allow it to dominate (in view of the consequences this entails)?
2. Is such a step possible (in view of what has actually occurred)?
3. If a preferred culture is chosen, according to which criteria? How can one create a hierarchy according to which democracy is preferable to tradition, or technology is valued above social ascription and commitment?
4. Who is entitled to determine the criteria for preference?

Culture and Multiculturalism

Prior to discussing the feasibility of creating and maintaining a single culture in a society containing various subcultures, and the conditions required to do so, we need to clarify the concepts of culture and multiculturalism.

Paraphrasing Taylor's classic definition, John Beattie maintains that "culture refers to the whole range of human activities which are learned and not instinctive, and which are transmitted from generation to generation through various learning processes." [5] Since this is an extremely broad definition, I shall use the narrower and more convenient concept of "way of life." According to Michael Thompson and Aaron Wildavsky,[6] "way of life" is a combination of patterns of interpersonal relationships and beliefs and values shared by a number of people or a group. For example, a pattern of relationships prevalent among members of a traditional rural family, combined with their beliefs about how to celebrate a festival and their concepts regarding the cause of illness (and these are the topics discussed below), constitute a way of life. It is one's way of life, according to Thompson, that channels the individual's thoughts, decisions and actions.

Multiculturalism is a relatively new concept. Its widespread use reflects the cultural differences that have persisted between various groupings that coexist within a common social framework, such as a country or a city, in modern society. Multiculturalism also often implies a value-based position that accords legitimacy to the very existence of different cultures within a society. This approach encourages researchers to expose and identify culturally different social groups and calls for appropriate action to be taken at the level of policy formation.

In Israel it has become clear that cultural disparities have continued to differentiate between various ethnic groups, particularly with regard to their religious practices, but also in other areas of life (for example, the Henna ceremony practiced by certain ethnic groups). During the past two decades the cultural diversity resulting from the great variety of Jewish ethnic origins has been strengthened by the waves of immigration from the former Soviet Union and Ethiopia. Furthermore, various socio-political processes have introduced the Arab population, with its various sectors, into the multicultural discourse. And in addition, new and clearly defined cultural groups, based on ideology rather than ethnicity, have appeared in recent years, such as the various left and right-wing movements.

In 1978 Sammy Smooha[7] identified three major categories in Israeli society, distinguished by their socio-cultural characteristics. These groups are defined according to rifts. The first of these is the ethnic rift, with oriental Jews

struggling against the Ashkenazis. Second is the nationalistic rift, with Jews set against Israeli Palestinians, while the cultural rift is drawn between the religious and secular elements of society. Later discussions[8] list a larger number of distinct cultural groups currently active in the Israeli arena.

While Smooha and Baruch Kimmerling emphasize the differences and the dimension of conflict between the groups, Eliezer Ben-Rafael extends the scope of discussion by proposing a number of factors that form the collective identity of a certain group. Ben-Rafael views the collective as defined primarily by its unifying attribute, with contradiction constituting only one of three elements of the group's cultural identity.

Both Kimmerling and Ben-Rafael make use of the term "cultural boundary," without explaining or conceptualizing it. The term refers to the boundary that differentiates between one group and another as a result of some kind of variance, be it religious, ideological, or a boundary that emanates from special ties to a unique type of music or literature.

I use the concept of cultural boundaries in analyzing the data of my research.

Research Population and Methods

My research was conducted in the nephrology department of Nahariya hospital in northern Israel, between July and September 2000, using mainly the participant observation method. Extended interviews with the patient population and with family members who accompanied them to their treatment were conducted in parallel. 70 of the 132 regular patients in the department were interviewed. The remaining 62 patients were excluded owing to communication difficulties (related to language and/or mental clarity). Additional interviews were conducted with members of staff —nurses, doctors, a dietician and a social worker.

Nahariya hospital serves the demographically and culturally heterogeneous population of the Western Galilee, which comprises Druse, Moslem and Christian Arabs, recent immigrants (mainly from the former Soviet Union), and veteran Jews living in communal settlements (kibbutz and moshav), development towns and cities in the area.

Dialysis Patients

The dialysis patients suffer from kidney malfunctioning, resulting in the accumulation of fluids in the body and varying degrees of inability to dispose of them. In parallel, certain toxins such as phosphorous and carotene accumulate in the body. General weakness and associated complications gradually affect bodily functions.

Kidney disease may have hereditary-genetic causes, such as marriage between relatives, or may develop as a result of other diseases, such as heart complaints and diabetes. The disease is characterized by a gradual deterioration of bodily functioning, leading to a state of total dependence and finally death. The development of the disease can be slowed down by means of appropriate medication (to counteract the phosphorus), or through adherence to a strict diet, which involves avoiding intake of fruit and vegetables (to reduce phosphorus and carotene), increasing the intake of dairy and meat products for their whole protein, and limiting the intake of liquids to two glasses per day. However, there is no prospect of improvement in the patient's condition by means of the above treatments. The only way of restoring the patient to a normal life style is by performing a kidney transplant, for which demand significantly outstrips supply. For this reason many transplants are performed surreptitiously.

Three distinct categories of kidney patients are treated by Nahariya hospital: outpatients, whose condition is less serious and who undergo periodic check-ups; patients who receive dialysis in their homes – a carefully selected population; and patients with severe kidney malfunctioning who require regular dialysis treatment in the hospital. The treatment is rendered by connecting the patient to a machine that cleans the body of the various toxins and extracts the fluids that are not disposed of naturally. Patients receive treatment that lasts 3-4 hours around three times a week, depending on the quantity of excess fluid.

The following analysis refers only to the third category, i.e., patients suffering from severe kidney malfunctioning.

Findings

My attention was drawn to the ethnic composition of the department's 132 patients (74 Jews and 58 Arabs and Druse). Among the veteran Israeli patient population, both Arabs and oriental Jews were over-represented in comparison to the ethnic distribution of the general population in the area. The largest single category (44% of the Jewish patients) comprised immigrants from the former Soviet Union. Since they are affected by factors in their country of origin, I do not discuss this category of patients here.

Jews of oriental origin make up 61% of the veteran Jewish patients, compared to only 51% in the general veteran Jewish population of the area. Among the veteran patient population Arabs constitute 59%, compared to only 47% in the general population.[9] Furthermore, Arabs constitute a clear majority of patients treated in the night shift, in which the treatment lasts longer than in the other shifts and to which patients who gain most weight between treatments owing to accumulation of fluids are assigned. This distribution raises interesting questions.[10] (The majority of staff members are Jews from various origins, including recent immigrants from the former Soviet Union. There is one Arab doctor and several Arab nurses).

Apart from the demographic characteristics of the patient population, differences between ethnic groups were found with regard to both the perception of the disease and to ways of dealing with the illness. The belief that "all is willed by Allah" held by many Arab patients and their families, while not necessarily leading to passive behavior with

regard to hospital visits and medication, is nevertheless associated with less effort to comply with dietary instructions and a greater reliance on medication. This belief thus serves as an excuse for failing to adhere to the strict dietary regime, which is the hardest aspect of the treatment.

Several differences in way of life were found, for instance, the tendency among Arabs to allocate a family member, generally a daughter, as a full-time helper to the patient. The daughter accompanies the father or mother to the hospital, and remains at their service in the home. As this is a long-term illness she does not marry, since her role definition precludes her from doing so. Also, whereas Jewish patients generally seek emotional support from the department's social worker, the Arab patients seek only material assistance.

The discussion below focuses mainly on a single aspect of dealing with the disease, namely compliance with treatment instructions. In the general research literature evidence is found of a link between ethnic origin and compliance in Japan, U.S. and Sweden[11]. When one examines the components that constitute the general term ethnic origin, we find that economic conditions, education and family structure all play a central role in the patient's behavior.

To establish whether there were different degrees of compliance among the various ethnic groups in the department I examined the degree of compliance with treatment instructions on the part of kidney patients through interviews with the patients themselves and with the staff of the dialysis unit. Significant differences in the degree of compliance between members of the different ethnic groups and between genders emerged. In general, Arabs were less compliant than Jews, and among the Jewish patients those of oriental origin, and particularly the men, were less likely to comply with the treatment instructions. Among Arabs, non-compliance was also more marked on the part of the men.

Analysis

Two culturally determined factors expose the Arab population to a higher risk of renal disease before they begin treatment in the dialysis unit. The phenomenon of marriage to a relative, common among rural Moslems in general and among the Druse in particular, provides a partial explanation of the higher rate of kidney malfunction among this section of the population, and their over-representation among patients treated in the night shift. An additional explanation is provided by delayed diagnosis owing to lack of knowledge and relatively inferior medical services. As a result, some of these patients' medical condition already necessitates dialysis treatment when diagnosed.

Compliance, or lack of it, may explain the differential pace of development of the disease. In other words, poor compliance accelerates development of the illness, hence the fast track to dialysis treatment and the disproportionate number of dialysis patients among this population.

A number of explanations may be offered regarding different rates of compliance among culturally distinct groups. The following points refer mainly to the Arab population, although some also apply to the oriental Jews.

1. The patients' traditional diet is inconsistent with the dietary instructions pertaining to their treatment. It is rich in vegetables and does not include dairy products. *Labaneh* (sour white cheese), one of the very few dairy items included in the Arab diet, is not good for the patients as it contains phosphorus. The change in diet demanded of Arabs is thus drastic and difficult to maintain.
2. An additional hardship concerns the eating patterns within the extended family; most of the rural Arab families are extended, family members generally eat together, and the individual finds it difficult to resist the food on the table.
3. Women traditionally do not eat dishes that are not eaten also by their children, and therefore do not prepare special dishes for themselves.
4. Both Jewish women of oriental origin and Arab women are obliged by their traditional social role definition to obey figures of authority. This may make it easier for them to comply with the dietary instructions given them by doctors and nurses.
5. Men, on the other hand, tend to find it difficult to accept the new regime. Their illness brings with it a loss of roles, in particular the role of breadwinner, loss of independent functioning and dependence on physical assistance from their wife and children, and loss of friends and a decline in social activity. In addition, "for us in the Arab culture to be ill," a patient told me, "is shameful." This role reversal leads men to cling to their remaining vestige of autonomy, albeit a negative one, and to eat as they like, in defiance of the dictates of the doctors and nurses and their representatives in the home—the women—who attempt to serve dishes in accordance with the medical instructions. Elderly men dependent on a daughter-in-law are embarrassed to ask for special food, as this emphasizes their weakness.
6. Rules of hospitality—guests are welcomed with large quantities of food. The frequent family and social events generally include a sumptuous feast. To avoid hurting the hosts' feelings the ill guest often consumes forbidden foods and drinks as well. In some cases patients sever their social ties rather than having to insult their hosts.
7. The economic situation also plays a role. Food supplements such as vitamins and meat are expensive and are beyond the means of many Arabs, many of whom belong to the lower economic strata.

Discussion

Following Mary Douglas[12], Thompson & Wildavsky[13] present a model that attempts to explain individuals' choices and preferences and the nature of their social relationships by means of two variables: the group and its boundaries (bounded units), and society's grip on the individual.

The former concept refers to the existence of clear distinctions between different social groups. Religious people, for example, dress and eat differently from secular people, and their marriage patterns also differ. The more a person is bound to and involved in a group with clearly defined boundaries, the harder it is for them to act differently to the group's norms of behavior.

The second concept of grip examines whether there are detailed rules that guide the individual's behavior within society: for example, when and where to pray, what to eat, how to make a living, whether to prefer study to work, and with whom and when to marry. Numerous rules of this kind increase society's grip on the individual and thus limit their area of choice and their capacity to make autonomous decisions.

The rural Arab population has a far more clearly defined collective identity than the Jewish population, although it too has internal divisions. Its language, religion, family organization, role division within the family, relations with neighbors, and concept of honor are all derived from the common culture or common way of life, which is passed on from generation to generation. Nevertheless, they all make use of the dialysis services offered by modern Western medicine, while some also comply with the additional treatment instructions concerning diet. Their cultural boundary is thus not hermetically sealed.

Examination of cultural differences between members of different groups of origin within the context of treatment for serious renal disease leads to a number of general conclusions:

1. The role of cultural boundaries in forming individual behavior: the more clearly defined are the boundaries, and the more detailed and binding are the rules of social behavior, the less latitude the individual has to choose a different course of behavior.
2. This indicates the secondary role played by economic factors in determining practical decisions regarding health-related behavior. Way of life has considerable influence even in matters of life and death.
3. The cultural boundary may be flexible. Arabs living in villages are willing to utilize modern Western medical services. Within the cultural boundary that distinguishes them there is room also for elements common to the general Israeli population.
4. A conclusion relating to multi-culturalism: the sub-culture prevalent in the patient's home recognizes the external culture of the hospital. On the other hand, while understanding the culture of the home, the hospital culture does not accept it, and views it as being obstructive. The staff members of the nephrological department try to persuade their patients to adopt different patterns of behavior and sometimes chastise those who fail to comply with the treatment instructions. Although their attempts to enforce compliance are driven by a genuine concern for the patients, they negate the principle of equality implicit in the ideological position derived from the multi-cultural approach.

Endnotes

1. See, for example, Shmuel N. Eisenstadt, *Israeli Society: Background, Development and Problems* (Jerusalem: Magnes, 1967) (Hebrew); Moshe Lisak and Dan Horowitz, *From Settlement to State: The Jews of Palestine in the Mandate Perios as a Political Community* (Tel Aviv: Am Oved., 1977) (Hebrew).
2. Jews of western origin.
3. Sammy Smooha, *Israel, Pluralism and Conflict* (Berkeley: University of California Press, 1978) and "Three Approaches in the Sociology of Ethnic Relations," *Megamot* 28 (1984) (Hebrew): 169–206; Shlomo Svirski, *Not Underdeveloped but Deprived: Orientals and Ashkenazis in Israel, Talks with Activists* (Haifa: Research and Criticism Papers, 1981) (Hebrew); Baruch Kimmerling, *The End of the Achusalim Regine* (Jerusalem: Keter., 2001). (Hebrew).
4. This is accepted also by veteran sociologists such as Moshe Lisak, *Mass Immigration in the Fifties—The Failure of the Melting Pot* (Jerusalem: Bialik, 1999). (Hebrew).
5. John Beattie, *Other Cultures* (London: Routledge, 1969), p. 20.
6. Michael Thompson and Aaron Wildavsky, *Cultural Theory* (Boulder, Col.: Westview Press, 1990).
7. Smooha, *Israel, Pluralism and Conflict*.
8. Baruch Kimmerling, "Kulturkampf," *Ha'aretz* 7 (1996). (Hebrew); Eliezer Ben-Rafael, "Collective Identity in Israel," in H. Herzog (ed.), *Society in the Mirror* (Tel Aviv: Ramot, 2000). (Hebrew)
9. The above data are based on an analysis of raw demographic data regarding the population of Western Galilee settlements, provided by the Central Bureau of Statistics, while taking into consideration the proportionate number of referrals to Nahariya and other regional hospitals (e.g., Afula, Haifa). The analysis was performed with the help of a statistician in Nahariya hospital's statistical department.
10. While these differences may not appear to be great, we should remember that they relate to the patient population at a given point in time. A comparison of the numbers of patients treated over a period of several years would probably reveal greater ethnically-related discrepancies.
11. Sherry Bame, N. Peterson, and N.P. Wray, "Variation in Hemodialysis Patients According to Demographic Characteristics," *Social Science and Medicine* 37 (1993): 1035–44; G.S. Tell et al, "Racial Differences in the Incidence of End-Stage Renal Disease," *Ethnicity and Health* 1 (1996): 21–31.
12. Mary Douglas, *In An Active Voice* (London: Routledge, 1982).
13. Michael Thompson and Aaron Wildavsky, *Cultural Theory.*