Beliefs and Behaviour in Transcultural Health Care - Miss S de Villiers

Miss S de Villiers
Dept of Anthropology, UNISA
PO Box 392
Pretoria
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Curriculum vitae

Stephne de Villiers is senior lecturer in the Dept of Anthropology and Indigenous Law at UNISA. She is busy with a D Litt et Phil degree in Anthropology about socio-cultural factors affecting the doctor-patient relationship.

Summary

Some socio-cultural principles are discussed which an anthropologist observed to be important in the clinical encounter between white doctor and black patient. Certain behavioural patterns influence the outcome of the encounter. A need is emphasized for a sensitivity towards patients whose belief-systems differ from that of the doctor.

S Afr Fam Pract 1991; 12: 44-9

KEYWORDS:
Anthropology; Physician-patient Relations; Cultural Characteristics.

A patient who consults a doctor has already evaluated his symptoms, considered a possible cause and made a provisional diagnosis according to his own health-care beliefs, knowledge and experience. Whenever a patient consults a doctor or a diviner, he is often seeking confirmation of his own diagnosis. In the context of the research upon which this article is based, the delivery of health-care occurred in a transcultural context where patient and doctor frequently have varying conceptions of the patient's condition stemming from different perspectives and perceptions which may be the result of different socio-cultural orientations. These differences have implications for the outcome of the clinical encounter. Much of what follows may be general knowledge to many doctors, but hopefully this article will emphasize the need for a sensitivity towards patients whose belief-systems differ largely from the doctor's own.

Aims

The aim of this article is to draw attention to some socio-cultural ideas and principles that are significant in the encounter between white medical practitioners and black patients in South Africa.

The anthropologist is concerned both with describing and explaining observed behaviour. The idea here is to provide anthropological explanations for some behavioural forms that influence the encounter between doctor and patient. The intention is not to suggest alternative forms of therapy, or that the anthropologist shares responsibility for treating the patient, but to state probabilities or possibilities based on specialist anthropological knowledge that underlie the behaviour of patients whose socio-cultural background differs from that of the doctor, and which the doctor should consider together with the medical requirements of a patient.[1] In this way the anthropologist may complement the doctor's skills and contribute to more effective provision of health-care in a transcultural setting.

Research Methodology

The research upon which this article is based, was undertaken among Xhosa-speaking patients in a provincial hospital in a rural town in the Eastern Cape in 1987. Not all the patients were townspeople; a third were resident on farms or in other places in the district. All who were interviewed were in a position to consult a non-Western practitioner, specifically an *igqirha* (diviner), if they so wished. Nineteen patients were selected for in-depth interviewing by the researcher, with due regard for their condition, length

of stay in hospital, age, sex and the prescription of medication that caused drowsiness. Where possible patients were also visited at home after their discharge for follow-up interviews. Data collected for each patient constitute a separate case study in which the influence of specific socio-cultural factors on the patient's perception of his or her condition, of the doctor and the hospital, and the influence of such factors on specific forms of health-care behaviour are emphasized. Interviews were also held with the six general practitioners in the town, with 20% of the members of the hospital nursing staff and with other townspeople who in some way are connected with the provision of health-care. Illustrative details used in the text thus all relate to the target group of Xhosa-speaking patients. The information does not permit generalization for all black patients or even for all Xhosa-speaking patients in South Africa, nor is it an exhaustive account of the field data. However, given their extended family context, the patients who were interviewed represent more than merely nineteen individuals.

A patient's own perception of the cause of the condition, influences his decision about which doctor to consult

Interviews were structured according to comprehensive research schedules. With the exception of two of the patients who were interviewed with the assistance of an interpreter, all the patients were interviewed in either English or Afrikaans. Where possible, observation formed an important part of the research procedure.

Ideas relating to causation of illness and consultation

A patient's perception of the cause of his condition influences his decision about whom to consult. The target population regard conditions either as being responsive to biomedical treatment or, alternatively, as conditions that may be categorized as *ukufa kwamaXhosa* (lit disease of Xhosa people), ie illnesses found among Xhosa-speaking people with a "supernatural" cause in terms of the Xhosa magico-religious tradition. Such conditions are usually regarded as not being responsive to biomedical treatment and patients consult an *igqirha* instead, although a doctor may be consulted for relief of symptoms. The informants however, attached different meanings to the concept of *ukufa kwamaXhosa* which ranged from the meaning presented above, to an exclusive meaning for the ancestrally-caused illness that leads to *ukuthwasa* or initiation as a diviner, to a condition that requires the patient to perform an *isiko* (custom), such as the ritual slaughtering of an animal. None of the patients identified their illness solely as *ukufa kwamaXhosa,* but ten of them believed that some form of supernatural causation was indeed relevant. With the exception of one, the informants all acknowledged that people suffered ill-health as a result of supernatural factors. It was also common to find a patient contemplating a possible "supernatural" cause in spite of the doctor's diagnosis.

Although all the informants indicated a preference for biomedical treatment, dual consultation of a doctor and an *igqirha* was common,[2] if not for the patient's present condition, then at an earlier stage for something else. Similarly, patients who surmised a supernatural cause were known to consult a doctor for medication for symptom relief before going to an *igqirha*. Concerning dual consultation two patterns could be discerned:

* prior consultation of an *igqirha* evident from small scratch marks on a patient's body or advanced symptomatology produced by the *igqirha's* medicine, and
* consultation of an *igqirha* on discharge from hospital, either to determine the cause of an illness, or the actions that were necessary to prevent its recurrence, or for alternative treatment if that of the doctor was regarded as ineffective or inadequate.

Rarely did patients mention that they had first consulted an *igqirha*, and they never did so voluntarily. Those who did acknowledge such practice had all initially regarded their disorder as having a "supernatural" origin. Thus, a bus driver with infective dermatitis sought the help of an *igqirha* because, in his view, the condition had been caused by co-workers who were jealous of his position and tried to remove him through sorcery. The diviner's treatment had limited effect, the condition recurred and the patient was eventually brought to hospital by his employer.

Dual consultation of a western doctor and an igqirha was common

The second pattern was mainly associated with patients whose condition was chronic or terminal. A patient with cancer of the liver was aware of the terminality of her condition. She asked to be discharged, on the one hand to be with her family, but on the other to consult an *igqirha*. She was discharged, but was readmitted and died in hospital soon after.

Besides the conception of their condition, additional factors that influenced the decision about whom to consult included access to biomedical facilities, the degree of Westernization, level of education, socio-economic position and status of the individual, the influence of relatives, friends or employers and the availability of money. It was common for patients to disregard diviners because of their fees.

The igqirha will inform the patient fully about his condition without the latter telling the igqirha anything about himself

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Typical of the patients who were interviewed was the inability to identify their condition in spite of the doctor's diagnosis. At most they described their condition with reference to the affected organ or part of the body where they perceived the sickness to be. Exceptions were patients who, for example, had diabetes, bronchitis, cancer or Parkinson's disease. Their ability to label their condition arose from the following:

* familiarity with the condition and its symptoms, either through their own experience or that of someone else;
* an awareness of specific, identifiable symptoms;
* in-depth information provided by a doctor.

All the informants indicated a desire to know the cause and prognosis of the condition, but those who did consult a doctor in this regard were the exception. Responses to the question why they had not asked the doctor included that they preferred to discuss the matter with a nurse, which in fact constituted the general pattern, that the doctor was in too much of a hurry to discuss such matters, or that they still intended doing so. From the perspective of the doctors and the nurses the reasons include shyness, lack of concern and submissiveness.

Xhosa-speaking people generally live in the context of an extended family in which the individual is of secondary significance to the family. Consequently, the influence of relatives, and particularly of the extended family, is important in health-care behaviour. Ill-health is seldom an individual experience and symptom evaluation and a provisional diagnosis are made in the context of the family.[3] The influence of relatives among the patients was apparent from general acknowledgement that consulting relatives was a primary factor in labelling their condition. Moreover, it could be deduced from patients' responses that pressure from kinsmen was decisive in their selection of an *igqirha* or a medical doctor for treatment. In this regard an important trend was that if a condition did not respond readily to treatment and relatives suggested the possibility of "supernatural" causation, a shift occurred in the patient's interpretation of his condition or in his ideas of its cause, and it was linked with some "supernatural" belief. This trend contributes significantly to patients' decision to request early discharge from hospital to consult an *igqirha* and clearly has implications for the patient's recovery.

Delayed consultation with patients revealing advanced symptoms is typical among the target population.

The patient is mostly a passive participant in his consultation with the igqirha

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Acknowledgement that the condition was initially not regarded as serious, previous but unsuccessful consultation of an *igqirha*, lay-care or self-medication, fear of job loss, transport difficulties in getting to a doctor or to the hospital and lack of money were given as reasons for this situation.

The Encounter between doctor and patient

General remarks

The doctors in the survey indicated that at most they have a vague conception of more exotic elements of the culture of their black patients, such as the belief in witchcraft and sorcery, the activities of diviners, or an awareness of ritual procedures that have significance for health-care. They are however, largely unaware of their patients' ideas about causation or of their conceptions of health and

ill-health. The implication of this situation is that the encounter between doctor and patient is often characterized by the involvement of different belief-systems relating to health-care.

Factors shaping the encounter and patient expectations

A patient who consults an *igqirha* does so in the knowledge that he will be fully informed about his condition without having to describe his symptoms. By virtue of his special powers, a diviner merely looks at the patient in order to make a diagnosis, or alternatively, to divine the cause of the condition.[4] This implies that the patient is sometimes a passive participant in the proceedings. We may surmise that this type of behaviour which forms part of Xhosa tradition, may, with due regard for specific personality traits of doctor and patient, play a role in the passivity or acquiescence typical of the informants. Among all the informants the view pertains that because of his training and the

Xhosa patients may withhold information from the doctor because of their beliefs

instruments he uses, the doctor should be able to determine the cause and provide a diagnosis without help from the patient.

A related explanation lies in the belief of some patients that there are certain aspects of one's condition that may be told to kin or to a diviner only. Thus a patient may present only those symptoms which he believes should be the concern of the doctor. If, in the patient's view, the doctor's questions are irrelevant or the answers are not his concern, he will withhold information. Alternatively, according to the doctors, patients who, for example, apply for a disability pension are known to be garrulous and to exaggerate their symptoms.

The former view is, however, counterbalanced by a readiness among patients to subject themselves to a physical examination which is not part of traditional Xhosa diagnostic procedure.[4] In fact, the target population regard a physical examination as an essential part of a visit to a doctor. Because of his training, which emphasizes physical examinations, a doctor is obliged to examine the patient. According to the doctors, it is not unknown for patients to start undressing before they are instructed to do so. In addition, in keeping with the findings of other studies,[5] the majority of informants maintained that an injection, over and above medication, is an essential part of a consultation, mainly because of the perception that it is more effective and works more rapidly than medication.[6] All the doctors interpreted this view in terms of their patients' belief that an injection comprises adequate or appropriate treatment.

Some form of diagnosis is also essential. If, in Xhosa tradition the idea of a diagnosis implies identifying the cause of the disease as well as naming it, a diviner always makes a diagnosis.[4] The informants indicated that they wanted to know what was wrong with them, a view supported by the doctors who maintain that they always give their patients a diagnosis, regardless of how vague or superficial. The effectiveness of the information given to a patient is however, in some cases questionable in view of the large number of patients who could not clearly identify what was wrong with them. The doctors and nurses ascribed this tendency to ignorance or lack of concern. Significantly, while a doctor may be baffled by a patient's symptoms, to state that he cannot find anything specific wrong, and

Some form of diagnosis is essential

hence is unable to provide a diagnosis, is unacceptable, again because this is contradictory to Xhosa tradition. To circumvent the problem the doctors gauge the patient's knowledge of physiology or anatomy and then describe an abnormality in a way in which the patient can understand. Thus, for example, a doctor mentioned that he indicates arthritis as rheumatism and hypertension as "high blood". Both concepts are recognized and understood by his patients.

The foregoing suggests that patients visit a doctor with definite expectations, not only with regard to being cured, but also regarding the way in which consultation should proceed. Unless these expectations are met, the patient leaves the encounter feeling dissatisfied, that he has not been treated adequately or that the doctor is incompetent, with negative implications for his recovery and for future relationships with the doctor.

The doctor-patient relationship

According to Jansen, an individual doctor-patient relationship does not exist in Xhosa tradition. A diagnosis is not given to the patient as an individual, but as a member of a kin-group.[4] By tradition a patient does not consult a diviner alone, but is accompanied by a kinsman who is witness to the consultation. This may provide an explanation for the number of patients who, according to the doctors, consult a doctor accompanied by someone else, usually a kinsman, who often acts as spokesman. It is not unknown for a patient to remain silent throughout the interview.

The majority of the informants were "state patients", which implies that they were usually examined by a doctor in his capacity as district surgeon, and consequently were not in a position to establish an ongoing relationship with a particular doctor. For some with chronic conditions it has happened that at a certain stage they have been patients of all the doctors in the town. Yet the informants referred to "my doctor" with regard to the doctor in charge of their case or alluded to a preference for a particular doctor, which implies acknowledgement of a type of relationship with the doctor. Alternatively, because of the limited size of the community and the small number of doctors, patients and doctors have in time been able to establish a type of doctor-patient relationship. Patients who can afford to pay a consultation fee of R10,00 may see the doctor of their choice and such patients are known to wait hours in order to do so.

Patients expect the consultation to proceed in a specific way

Patient acquiescence and related matters

For the patient the position of the doctor is one of extreme prestige because of his advanced education and the nature of his work. In Xhosa tradition prestige is linked to positions of authority and consequently high expectations are made of persons in such positions. Individuals are required to defer to them, such behaviour usually being manifest in acquiescence and attempts to please. Similar attitudes characterize consultations with an *iggirha*, ie an authoritative person,[4] although greater freedom of communication is evident because practitioner and patient speak the same language and share health-care beliefs. One may presume that such attitudes are transposed to the doctor-patient encounter which are then manifest in acquiescence which in turn, may be interpreted as submissiveness instead of as acts of deference. The point is however, that a Xhosa-speaking patient may be culturally conditioned to behaving submissively in the presence of a doctor. If this principle is acknowledged it becomes possible to anticipate and to interpret behaviour patterns.

A significant factor in this regard concerns the South African political situation. Whites are usually in positions of authority, consequently the "master-servant" relationship has conditioned black patients to be submissive in the presence of a white doctor. In addition, the hospital is regarded as "the place of whites", so the patient finds himself in a strange environment that he associates with people with whom he has had little, if any, opportunity for establishing meaningful relationships.

Traditional attitudes are transposed to the doctor-patient encounter

A matter related to the tendency towards acquiescence is the indirect manner in which patients, particularly women, often describe their symptoms or discuss a problem, most frequently if it concerns infertility. The nurses stressed that infertility is of great concern for women and they are uncomfortable talking about something so intimate, particularly to a man. While the doctors regard this as standard behaviour or interpret it in terms of the expectation that Xhosa-speaking women should bear children, a compounding factor may be the Xhosa custom of *ukuhlonipha* that prescribes that a woman should not address her husband's father and other senior male relatives directly, never use their names, and should heed avoidance behaviour with regard to them.[4] A type of distinctive "language" is sometimes used in communication with such relatives and it is possible that the principles underlying *ukuhlonipha* may be causative with regard to circuitous discussions and patient submissiveness in the presence of a doctor.

It is however, also possible that some patients do not possess adequate English or Afrikaans vocabulary to

describe their symptoms clearly, or that *isiXhosa* does not include terms for providing descriptions appropriate to biomedicine, hence a patient's inability to do so even through an interpreter. This gives rise to a particular way of describing symptoms such as having "a hole in my back", or the idea of something "crawling up my leg". Similarly, with the exception of one, the doctors were unable to speak *isiXhosa*. This situation either made the services of an interpreter necessary or produced the situation where a patient later asked a nurse to repeat what the doctor had said.

Conclusions

While it is acknowledged that some of the patterns identified above can be explained in terms of human nature, with the implication that the health-care behaviour of Xhosa-speaking patients is not necessarily different from that of other patients, a patient's socio-cultural orientation influences his perception and identification of his condition, and consequently his health-care behaviour. That a Xhosa-speaking patient consults a doctor should not be interpreted as though he no longer retains elements of Xhosa tradition in his health-care beliefs. What becomes evident is situational behaviour or a form of compartmentalization with regard to health-care behaviour and patients can only be understood in the context of their lifestyles and their belief-systems.

This has particular significance in South Africa where many black patients consult white doctors, which means that the medical encounter often occurs in a transcultural context. Where the patient's and the doctor's conceptions of the condition differ, problems may arise in the clinical setting, reducing the effectiveness of the medical encounter with negative implications for the treatment and recovery of the patient. While modern medicine is largely effective regardless of the patient's socio-cultural orientation, the patient's recovery is linked to his awareness that the doctor is sensitive to his perception of his condition. The provision of health-care is promoted when doctor and patient have the same culture,[7] but where this is lacking, the doctor should acquaint himself with his patient' perceptions of ill-health.

End note

The research upon which this study is based was undertaken with funds from the Research and Bursaries Committee of the University of South Africa, which is gratefully acknowledged here. Findings of the research are my own and do not represent the views of the University.

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