

“The dilemma of the first world SA doctor and the third world patient”

— Russell Kirkby

Mr ECT a 44 year old married Zulu presented with the following letter from his employer:

“The abovementioned employee has been sent to Hospital on four occasions over the past four months. The employee’s condition has not improved, and has in fact deteriorated. The hospital has continuously referred to a fracture in one of his toes but the man appears to be suffering from some kind of illness and has complained about a pain and semi-paralysis on his left side.

The employee has requested that he be given the time to have a consultation with yourself to further investigate his illness. We are a company who are concerned about the health and well-being of our employees and have found Mr ECT to represent a safety hazard to his fellow employees in his present state of health.

I sincerely hope that you will be able to identify Mr ECT’s ailment and take the necessary corrective measures to restore him to good health”.

Is the 3rd World patient better off with the traditional Western approach?

Examination revealed that he had some stigmata of excessive alcohol abuse (Gynaecomastia, peripheral neuropathy) as well as flat feet and metatarsalgia. He is a labourer and stands all day. He apparently had had his hip, femur, feet and chest X-rayed

at hospital but the treatment had not helped. He was told that his foot pain was due to some previous fracture. Discussion revealed that he believed he was afflicted by Umeqo. An enemy of his who had worked with him previously had placed a spell on him. This man still had friends in the company and these friends had probably laid the “muti” in his path. When he had walked over this he had become ill.

The question here is whether this man is better served by traditional Western type medicine — as he had unsuccessfully been for four months — or whether a “Charlatan” armed with his Vit BCo injection and pills (which could also help his ethanolic neuropathy) would be more successful with his explanation of the disease in terms of reference the patient could understand. He will be given medicine to strengthen him against bewitchment. This latter approach seems to have had the desired effect — and the costs in comparison?

Food for thought.

What is Umeqo?

Wessels describes this as “attributed to sorcery, having stepped over dangerous tracks or the placement of harmful medicines.”

Patients have described this as:

Some person who dislikes you or is jealous of you goes to an Inyanga (Herbalist) who provides umuthi. This is sprinkled around to “thakhata” you. If you step over these “tracks of muthi” you become ill and afflicted with all sorts of complaints.

This is especially to do with aching joints and muscles.

“Idliso” is another common cause of illness, especially concerning com-

plaints pertaining to the chest or abdomen.

Someone who dislikes you obtains poison from an Inyanga or Isangoma and contaminates your food or drink. In this way you are “poisoned” and become ill.

In both *Umeqo* and *Idliso* the important facet is that someone is the cause of your illness (enemies, wife, family member etc) and not something eg a germ. The germ may make you sick or cause the disease process but someone is responsible for you becoming “weak and losing strength” eg Tuberculosis is caused by someone poisoning you. (Wives and family are commonly “suspected”).

Likewise Peptic Ulceration (the pain and dyspepsia) have occurred because someone has poisoned your food.

Someone who dislikes you is the cause of the illness

Wessels¹ emphasised:

“All people understand illness and misfortune in terms of their specific cultural model. Explanations and treatment outside this model are unacceptable, confusing and ineffective.

Mutwa² in discussing traditional healing quoted Chris Barnard as saying:

“It all boils down to faith and if the patient has no faith in you as a Physician you can give him the best medicines and he will still die.”

There is little doubt that most doctors in this country come from the so-called First World group of people and most patients in this country can still be considered as Third World people.

There is very little doubt that our medical training is by and large Western orientated and First World standard orientated. When we administer medicine and the practice of medicine to a First World population it is generally accepted and we are comfortable in our role.

However is this the case when dealing with Third World people?

Their traditional healers do not practice medicine the same way that we do. Our traditional approach of history taking by exhaustive interrogation, physical examination, special examination, diagnosis and then treatment would appear not to find favour with the majority of these people. Their concepts as to the causation of illness differ widely from ours and our general acknowledgement of their beliefs, customs and practices is usually one of ridicule, incredulity and disdain.

It is therefore not surprising that we experience such a large incidence of non-compliance with treatment and poor success rate in many spheres eg eradication of measles, treatment of Tuberculosis. How often does the First World doctor not just shrug his shoulders resignedly and think "This

Non-compliance is therefore not surprising

is the way of Africa" when he sees patients hopping around from hospital to hospital having the same investigations performed, never returning for follow up and then returning in a parlous state eg in a diabetic coma or heart failure, where their "neglect of condition has landed them."

Does it never cross our "developed" and "educated" minds that we might be a prime cause of the situation by not addressing the needs of our patients in ways and means they can

understand. Nowhere is this more apparent than in the private sector. Here we see many Third World patients drifting around, refusing hospital treatment because "they never get helped there", moving from doctor to doctor in search of that magical cure.

Does it not cross our "developed" and "educated" minds that we might be a prime cause . . .

I think in hospital and clinic type practice one is fairly protected because of pressures of work and volume of work. It doesn't matter if patients do not comply or turn up. There are many more pressing needs than to consider the so-called failure of treatment and it is easier just to dismiss it as ignorance and unavoidable.

However in the private sector there are many practices that can and do cater to these Third World patients very effectively. They do so by addressing their medical needs with a Third World approach ie. they take a leaf out of the traditional healer's book. Also doctors practicing this Art of Medicine have an understanding of their patients' language, culture, beliefs and especially their beliefs and expectations when it comes to disease and medical treatment.

Let us for example take the following:

A one year old child with a high fever, the clinical signs of conjunctivitis, stomatitis, bronchopneumonia, dehydration and a typical measles rash.

The First World Approach:

1. History as to onset of symptoms and signs including immunization, contact with measles etc.
2. Examination.
3. Special investigations eg Chest X-ray.
4. Diagnosis of measles.
5. Treatment.

The mother here generally wants to know what caused the disease and is

satisfied when you explain that this is from the measles germ.

"Third World Approach"

1. No history is asked for.
2. Proceed directly to examination.
3. Describe in detail your findings to mother eg Your child is ill and has a high fever. He is losing strength and does not like food. He has a rash on his body and sores in his eyes, mouth and chest. He is coughing and also has runny stools.

The mother is impressed that you have divined the disease and is not really interested in your clever diagnosis of measles. She is more concerned that you will treat it by giving it strengthening medicine (the injection) to offset the cause of the illness. To her mind the child became susceptible to the disease because of Umeqo. This made him weak and then the disease struck. Not to treat the cause (Umeqo) would be unacceptable and make compliance with the rest of the treatment less likely.

The "Third World Approach" seems unscientific and mumbo-jumbo but mimics what the traditional healers practice ie throwing of bones to divine the illness. One does not take a history but proceeds directly to examination, followed by a description of your findings (ie diagnosis) and proposed management.

The doctor adopting this approach has to:

1. Attempt to make a spot diagnosis as the patient walks in eg Hemiplegia, Scabies, Parkinsons.
2. Look for clues from the traditional healers — the scars of the treatment administered to the affected area often indicate where the problem lies.
3. Describe obvious signs and symptoms

No history is asked for

toms eg Obvious clinical cardiac failure — description of dyspnoea, oedema. Skin lesions, chest signs etc, are also easy to describe.

4. The problem arises when an ostensibly healthy patient presents and there are no clinical signs to aid you. Generally when these patients present to the doctor it is because they

feel unwell or ill. If one suffers some generalisation eg "You are feeling run down and tired, you have no energy", the patient will usually agree.

The patient will then say something like: "Yes that is so but I also have, for example, a sore throat." You look in his throat and see a florid follicular tonsillitis.

Strange, as this may seem it appears that many patients prefer this approach than our customary way of asking them what is wrong with them.

The Dilemma

What does a Western orientated First World trained doctor do? In the practice of his medicine where he is comfortable he reaches only a small proportion of the population. Hence they tend to be overdoctored and overserved because this is the only mode where this doctor feels comfortable and where he knows what he is doing. If he resorts to treating Third World patients with the Third World approach he has the problem of often being looked upon by his colleagues as a charlatan and an exploiter of the underprivileged and uneducated. Very often he has a superficial or no knowledge of their language, customs, beliefs and practices. This doctor can either adopt one of the following options:

1. He can remain in the First World and add to the overdoctored and overserving there but at least he is comfortable and happy. He then has to deal with his guilt feelings of

leaving the majority of the patients at an even greater disadvantage and adding to the maldistribution of doctors in South Africa.

2. He can continue to treat Third World patients in his Western and First World orientated way and be frustrated at every turn by non compliance and seemingly overwhelming odds.

The doctor who speaks the local language, understands their beliefs, traditions and customs is often happy treating patients with a "Third World Approach" because he knows and sees its value and success. The misinformed derision and opinion of his "more learned" colleagues does not phase him as he has much first hand evidence of the failures of their First World approach.

The Third World approach must be researched and developed

In between is the doctor who sees the value of the "Third World Approach" but is frustrated in his practice of this. This is because his knowledge of the language, customs and beliefs is deficient. Accordingly he dabbles in both worlds usually unsuccessfully and frustratingly.

Is there a way out of this dilemma? I believe we have to recognise that

this set of circumstances exists. There are going to be Third World patients with us for many years and we cannot negate or forget about these people's customs and beliefs by pooh-poohing them or pretending they do not exist. We cannot also just adopt the approach that if they don't accept our way of practicing, well then that's their own problem.

There is much to be said for the "Third World Approach" to these people. Those that practice it effectively must publicise their efforts. It must be researched, refined and developed into another tool for effective medical care.

To have medical courses that do not incorporate teaching of local languages, customs and beliefs is nonsensical.

At present in our approach to these patients our vision is as clouded as someone with the opaque lenses of cataracts. Is it not time for an aggressive surgical approach to remove the denatured protein of clouded vision and the fitting of corrective spectacles so that we can see the wood inbetween the trees?

References

1. Wessels W H. Understanding Culture — Specific Syndromes in South Africa — The Western Dilemma. Mod Medicine SA 1985; Sept 15: 51-63.
2. S A M J News Traditional Healing An Interview with Credo Mutwa. S Afr Med J 1986; 70: ix-x.

Erratum to Drug Profile:

Chloroquine Vol. 9 No. 5 May 1988 pages 202-204.

Treatment of malaria

● *Children:* orally, total dose is 25 mg base/kg; initiating with 10 mg/kg on days 1 and 2, and 5 mg/kg on day 3, in suitably divided doses. IV or IM not more than 5 mg base/kg repeated once after 6 hours: the total dose in 24 hours should not exceed 10 mg/kg.

Learning from Patients

Many medical educationists are encouraging under- and post-graduate students to cultivate the habit of learning from their patients. This is seen as one's main, life-long learning strategy for initial and continued education. We invite you to send us an account of your learning

experiences with and from patients. If not in the form of an article, why not write us a letter?

Editor

Please address your correspondence to:
The Editor
SA Family Practice
PO Box 40447, Arcadia 0007
Republic of South Africa

Are you an Academy Member?

