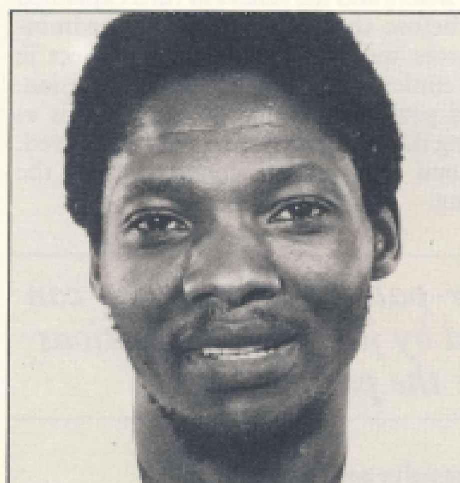
Attitudes of rural African patients toward the use of drugs as prescribed by doctors

— K Mfenyana



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Curriculum vitae

Dr Khanya Mfenyana obtained a BSc degree at the University of Fort Hare in 1970. He then studied at the University of Natal and obtained the MB ChB degree (1977). He worked in the Transkei as a General Practitioner for 8 years during which period he obtained the MPrax Med degree in 1984 at Medunsa. He joined the Department of Family Medicine at Ga-Rankuwa Hospital/Medunsa as a Medical Officer/Lecturer in January 1987 and was promoted to Senior Medical Officer/Senior Lecturer in July 1987 to date.

Summary

A descriptive study was done in Mount Frere District (Transkei) on what patients expect from their doctors regarding treatment: advice, medication, injections. The findings are interpreted especially as regards the effect of treatment on the doctor-patient-relationship.

S Afr Fam Pract 1988; 9: 137-42

KEYWORDS: Attitude; Drug Therapy, Combination; Physician-Patient Relations.

In predominantly black practices General Practitioners tend to prescribe an injection, 2 or 3 sets of tablets and a bottle of medicine for each and every patient seen irrespective of the illness.

A descriptive study was undertaken to find out what the rural African people of the Mount Frere district, Transkei, expected from their doctors regarding treatment for their illnesses.

The study was carried out during the period September 1981 to August 1984 at the rural and mobile clinics — the Mount Frere district of Transkei.

Systematic sampling was chosen and the sample size was 1 000. A questionnaire of eleven closed questions was used. The questions were framed in such a way as to elicit the attitudes of the people towards the various types of treatment ie injections, tablets and mixtures. The eleventh question referred to attitudes towards advice. The sisters at the clinics and mobile division were responsible for administering the questionnaires to the people. The main finding was that many rural Africans still expect an injection, tablets and a bottle of medicine for each consultation. A consultation without an injection was regarded as incomplete, especially for the older people, people with little education and people living in areas served only by the mobile clinic.

I became interested in the matter after getting comments from patients especially about injections such as:

- "I will always come to you for medical attention because I have never been given treatment by any private practitioner before without an injection. I am very thankful for not getting it as I am scared of it." — *Minister of Religion*
- "Do not forget to include an injection. I believe in it too much. Treatment without an injection is incomplete." — *Attorney*
- "I want an injection for "Igazi", (that is "blood"). I feel weak generally." — *No formal education*

- "I believe in an injection because I need immediate relief. I am lazy to take tablets especially 3 or 4 times a day. I normally take them on the 1st day only. The reason is that I am hardworking and forgetful." — *Promiment Businessman in town*
- "I want an injection for Veneral Disease. I do not want tablets because my wife will see them." — *Teacher*
- "I was told by a doctor not to take an injection of any type. I did not inquire why." — *Schoolgirl, obviously scared of an injection.*

Many rural Africans expect an injection, some tablets and a bottle of medicine with each consultation

Method

The selected study population was defined by geographical location; thus the administrative area of Mount Frere was used. Systematic sampling was chosen and every 3rd person from the queue of people attending the clinics with resident nurses and the mobile clinics, was selected. The first person in the queue was chosen as the first member of the sample. The data was collected from September 1981 to February 1982. A 1 000 subjects were chosen.

Fig 1 The Questionnaire

	Yes	No
1. Are you satisfied with medical Rx without an injection?		
2. Do you think that an injection alone can cure disease?		
3. Are you satisfied with medical Rx consisting of tablets only?		
4. Do you get confused when different types of tablets are prescribed?		
5. Do you get confused when different types of tablets are prescribed to be administered at different times?		
6. Do you think that the bottle of medicine normally given by doctors is too small?		
7. Do you think that it is necessary to get a bottle of medicine each time you visit a doctor?		
8. Do you think that it is necessary to continue treatment after full recovery?		
9. Do you sometimes consult a doctor with a desire to get a particular drug?		
10. Do you sometimes consult a doctor with a desire for a particular drug without medical examinations?		
11. Do you sometimes consult a doctor for medical advice only?		

A questionnaire was chosen as the means for obtaining the information from the people. Fig 1.

Method of Data Collection

There were only six resident clinics at Mount Frere at that time. The rest of the administrative area was served by a mobile division. By mobile division it is meant a group of nurses travelling daily, from Monday to Thursday, to the various locations with no resident clinics to render medical services. The mobile teams saw patients at set points, using houses belonging to individuals in the community. The project was explained to the sisters and the sisters in turn explained to the patients before the questionnaire was administered. Ten sisters were involved in this project ie 6 at the resident clinics and 4 from the mobile division. Both sisters and patients were excited about this as they were wanting the medical services to be improved. One thousand and eleven were collected from the sisters' processing.

The doctor-patient-relationship can be harmed by just giving injections for the placebo effect

Summary of results and discussion

Data was analysed by age, educational level and type of clinic. Four levels of education were used.

0 = No formal education
1 = lower primary education (4 years of schooling)
2 = higher primary education (5 to 7 years of schooling)
3 = secondary education and more.
The respondents were female in 98% of cases.

Injections

The majority of the rural African people preferred injections every time they consulted a doctor. However, younger people (table 1), educated people (table 2) and people treated at resident clinics (where there is continuity of care) behaved differently from the older people (table 3), people with little education and people served by mobile division (where there is intermittent medical care). The former group was less in favour of injections.

Studies by Unterhalter[1] and Buchanan[2] showed that Urban Blacks preferred tablets for themselves; whilst preferring injections for their children for "quick action".

Tablets and mixtures

The rural Blacks were not happy with pills as a sole medication. However, the statistical difference between educated people (table 4) and people with resident medical services on one side (table 5); and people with little education and with poor mobile services on the other side, is encouraging. The former seem to be aware of the fact that tablets alone can

Table 1: Injection and Age

Treatment without Injection			
Age (yrs)	Satisfied (%)	Dissatisfied (%)	Total
< 24	53 (18)	240 (82)	293
> 24	73 (10)	634 (90)	707
Total	126 (13)	874 (87)	1 000

$X^2 = 10{,}64$ $P < 0{,}01$

Table 2: Injection and Education

Treatment without Injection			
Education	Satisfied (%)	Dissatisfied (%)	Total
0	6 (22)	21 (78)	27
1	9 (6)	147 (94)	156
2	44 (9)	466 (91)	510
3	68 (22)	239 (78)	307
Total	127 (13)	873 (87)	1 000

$X^2 = 41{,}30$ $P < 0{,}001$

Table 3: Injection and Clinic Type

Treatment without Injection			
Clinic type	Satisfied (%)	Dissatisfied (%)	Total
Mobile	75 (11)	603 (89)	678
Resident	53 (16)	269 (84)	322
Total	128 (13)	872 (87)	1 000

$X^2 = 6{,}19$ $P < 0{,}01$

Table 4: Tablets and Education

Treatment with Tablets only			
Education	Satisfied (%)	Dissatisfied (%)	Total
0 + 1	18 (10)	164 (90)	182
2	47 (9)	462 (91)	509
3	60 (19)	249 (81)	309
Total	125 (13)	875 (87)	1 000

$X^2 = 19{,}65$ $P < 0{,}001$

Table 5: Tablets and Clinic Type

Treatment with Tablets Only			
Clinic type	Satisfied (%)	Dissatisfied (%)	Total
Mobile	66 (10)	612 (90)	678
Resident	60 (19)	262 (81)	322
Total	126 (13)	874 (87)	1 000

$X^2 = 16{,}52$ $P < 0{,}001$

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be just as effective in controlling illness or disease. The majority in all groups felt that a bottle of medicine was always necessary. Education did not show a statistical difference but the age (table 6) and type of clinic did (table 7). The young, and people with resident medical services did not feel as strongly about getting a mixture as the older people and people with mobile medical services.

Complex medication

From this study, different types of tablets administered at home at different times did not seem to confuse the people. This is contrary to the literature on studies done on Urban Blacks. Studies by Buchanan and

Table 6: Mixture and Age

Necessity of a Bottle of Medicine			
Age (yrs)	Always (%)	Not Always (%)	Total
< 24	202 (69)	91 (31)	293
> 24	540 (76)	167 (24)	707
Total	742 (74)	258 (26)	1 000

$X^2 = 6,38 \quad P < 0,001$

Table 7: Mixture and Clinic Type

Necessity of a Bottle of Medicine			
Clinic type	Always (%)	Not always (%)	Total
Mobile	540 (80)	138 (20)	678
Resident	202 (63)	120 (37)	322
Total	742 (74)	258 (26)	1 000

$X^2 = 31,74 \quad P < 0,001$

Mashigo[3] and Buchanan and Mtangai[4] showed that "it can be confusing when different dosage regimes are prescribed for the treatment of one period of illness. Also the more drugs prescribed, the lower the degree of compliance." Maybe our rural patients did not want to admit to the fact that complex treatment may be confusing so as not to influence the doctor or nurse to give less drugs.

Advice

As for advice only, very few people in this study consulted a doctor for it. The few who consulted a doctor for advice only, were young girls who wanted advice regarding contraception. People who visited a

doctor for medical advice only did not expect to pay. Afterall, there were some who consulted a doctor for nonmedical advice which was not charged for.

> *". . . to establish a good relationship with his patient where the patient is willing to pay even if he gets advice only"*

Conclusions

The Standard Ritual by which every consultation ends with an injection, 2 or 3 types of tablets and a bottle of medicine has the following advantages and disadvantages:

Advantages

(a) The patient knows what to expect when consulting a doctor.

(b) The patient goes home satisfied.

(c) It is therefore the easiest line for the doctor to follow.

Disadvantages

(a) No individuality is considered.

(b) Drugs are being wasted.

(c) Patients are increasingly exposed to side effects of drugs.

(d) Doctors are tempted not to give enough supplies for the necessary treatment because there are other modes of treatment to be included

Doctors have shown *injections* to be powerful with vaccinations, morphine and penicillin. Traditional healers have also contributed to this as demonstrated by Inyanga marks on most patients. I was made to understand by older colleagues, that people used to be charged more money if an injection was included in the treatment.

However, individuality should be considered as there are people who hate injections. People with no formal education seem to allow the doctor to decide what is best for them. People with secondary education seem to be aware of the placebo effect of vitamin B Co injections and this can affect the Doctor-patient relationship.

At the moment, very few people consult a doctor for

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medical advice. Our patients see two different doctors on one day about the same problem when not satisfied or have no confidence in the former doctor. They are not happy with advice without medication no matter what the illness is. The success in a doctor-patient relationship, therefore, would be achieved when a patient is willing to pay for medical advice only. This, in my opinion, should be the ultimate goal of every family doctor. A placebo should only be seen as failure in establishing a good doctor-patient relationship.

References

1. Unterhalter B. Compliance with western medical treatment in a group of Black ambulatory hospital patients. *Soc Sci Med* 1979; **13**: 621-30
2. Buchanan N, Shuenyane E, Mashigo S, et al. Factors influencing drug compliance in ambulatory Black urban patients. *S Afr Med J* 1979: 368-73
3. Buchanan N, Mashigo S. Problems in prescribing for ambulatory Black children. *S Afr Med J* 1977; **52**: 227-9.
4. Mtangai P, Buchanan N. Problems in prescribing for ambulatory Black adults. *Cent Afr J Med* 1977; **22**: 289-92.

From the Journals

Primary Prevention: A new look at basic concepts

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Soc Sci Med 1987; 25 (8): 923-30.

Abstract Personal health and well-being are gaining priority on the American agenda. A renewed interest in health promotion has been facilitated by the need to contain health care costs, realization of the limits of medicine in preventing illness, and a deeply rooted societal ethic of personal responsibility for individual health. Although the health status of Americans has changed significantly for the better during this century, further improvements are necessary, especially among high risk subgroups within the population who have not been effectively reached by traditional health promotion strategies. Past efforts, aimed at individuals modifying their risk factors, have neglected to address environmental factors that contribute to disease risk. This points to the need for an integrated approach where problems are addressed as properties of the systems in which individuals behave. This paper reviews selected health trends in the United States, discusses limitations of the current approach to health promotion, presents a comprehensive definition of prevention and provides principles for planning that may facilitate improved health status in this country.

Health Promotion Talk in Family Practice Encounters

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Soc Sci Med 1987; 25 (8): 961-99.

Abstract The model of family medicine advocates a view of the patient as a psychosocially grounded person, and stresses the value of a preventive approach in maintaining health. Given such principles, it is expected that in the expression of this model — in actual family practice encounters — physicians will regularly introduce topics about health promoting behaviours in their interactions with patients. Examination of a sample of typical and unrehearsed encounters between family physicians and patients, however, reveals a striking absence of such topics. Where they do occur, there is conversational evidence that both parties find the topics troublesome, and employ conversational strategies which tend to distance these topics from the rest of the interview. The conversational features of these distancing strategies, as well as their possible sources and implications, are discussed. Physician participants in the research express no reluctance to introduce topics related to health promotion behaviour, and in fact report that they do so regularly: the latter is contradicted by empirical conversational data. Difficulties that physicians evidence in managing these topics — in the absence of any conscious dispreference — suggest that shared interpretive frames operating for the remainder of the medical encounter do not work well for these topics. Physicians desiring to communicate effectively in this area may need to rethink health promotion talk as a special conversational task, which differs in key ways, from more conventional topics introduced in medical encounters.

Family-Practice Anesthesia in British Columbia

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Abstract This study of family practitioners as anesthetists is based on data extracted from records of the Medical Services Plan of British Columbia. During the period from 1976 to 1986, the proportion of anesthetics that were administered by non-certified anesthetists declined from 28.3% to 22.1% of the total number. Small and medium-sized hospitals continue to depend on family-physician anesthetists. Family practitioners make up 96.9% of all anesthetists practising in hospitals with fewer than 50 beds and 88.2% of anesthetists in hospitals with 50-99 beds. Rural areas are served almost exclusively by family-practice anesthetists, since 16 of 29 BC regional districts have one or no certified anesthetists. The author discusses the implications of this situation for the future of family-practice anesthesia.