Choice of Healer:
An important area of interest for general practitioners

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Curriculum Vitae
Emile André Boonzaier graduated from UCT (BA, B.Soc. Sc, BH Hons, MA) in 1973-76 : Majored in psychology, sociology and social anthropology. 1977-1980 post-graduate research in social anthropology focussed on Richtersveld Rural Areas in Namaqualand. Since 1981 he has been an Assistant Lecturer at the Department of Social Anthropology, UCT. Also currently involved in teaching programmes for first-year MB ChB and post graduate M Med students in Community Health. Special interest — the application of social sciences to medical settings.

Summary
This paper emphasizes the universal aspects of the choice of healer by patients, and the whole range and variety of healing resources which patients are consulting as well as the motivations affecting such choices. GPs should be aware of this reality.

KEYWORDS: Patient Acceptance of Health Care; Physicians, Family; Physician-patient relations; Private Practice; Hospital personnel; Fees, Medical; Medicine, Traditional; Self Medication.

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THE recent article *'Why the private doctor'* (van Selm, 1984)[1] focusses attention on a number of important issues which concern the general practitioner in South Africa. However, the problem of choice of healer is much broader than the simple question of whether and why certain patients at certain times prefer to consult private doctors rather than those in State institutions, and this paper attempts to outline some additional dimensions.

CHOICE WITHIN WESTERN MEDICINE

The hierarchical structure and system of referral within the medical profession, as well as the availability and cost, all limit the patient's choice. For example, in certain rural areas where there is a notorious shortage of

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private doctors and hospitals, patients are virtually obligated to attend the local clinics as their first ports of call. Similarly, patients who consult their local GPs have little say as to whether, when and where they are to be referred. But notwithstanding such restrictions, patients tend to develop preferences and antagonisms and try to exercise some degree of choice within the Western medical system. For example, where it is at all financially feasable, patients might be prepared to incur the great cost of consulting a private practitioner in order to avoid the long waits and impersonal treatment usually associated with State medical institutions.[A] Many patients are also able to choose a particular general practitioner — here a variety of factors, such as the manner, age and sex of doctors or their willingness to spend time with individual patients or to prescribe certain drugs, are all important.

CHOICE BETWEEN MEDICAL SYSTEMS

A wide range of healing options, many of which fall outside the boundaries of 'Western medicine' (such as homeopaths, naturopaths, chiropractors, faith healers or indigenous African healers), is available to patients. Most patients make use of such healers ***in addition to*** healers who practice within the Western medical tradition. In other words, patients can and do exercise significant choice in movement ***between*** different medical systems.

In South Africa there has until very recently been a widespread belief that Africans persisted in consulting 'witchdoctors'[B] due to what were generally referred to as 'cultural factors'.

There is a widespread notion that ***all*** Africans or Blacks consult ***only*** the traditional type of healers. Obviously the first part of such an assertion is patently false, as any doctor can vouch. But unfortunately many people still believe that it is an either/or situation — some Africans consult only Western doctors, while others consult only traditional 'witchdoctors'. It is also generally assumed that the higher the education of patients, the less likely they are to consult 'traditional' healers.

Various researchers have emphasized the fallacy of such notions, and they have demonstrated the degree to which patients attempt to get 'the best of both worlds' (See, for example, Janzen, 1978[3] or Maclean, 1971).[4]

A. The extent to which the introduction of medical aid schemes has decreased the cost born by the individual when making such a choice should not be underestimated.

B. " 'Witchdoctor' now carries so many connotations and the word has become so coloured by exaggeration that it should perhaps be discarded in favour of the more accurate term 'diviner': but it simply means one who doctors against witches." (West, 1976: 11)[2] Nonetheless, the term is generally used (albeit inaccurately) to refer to any healer with an African flavour and who is not part of the Western medical enterprises, and it is in this sense that the term is used here.

> ***Patients attempt to get the best of both worlds — the traditional and the Western healer.***

Furthermore, the motivations for not making more use of Western healing resources has much less to do with the cultural predilections of patients than with perceived objective differences between medical systems. For example, in one of the earliest anthropological studies addressing the issue of choice of healer, Saunders summarizes the differences between Western and Spanish-American folk medicine as follows:

> *Anglo-scientific medicine involves largely impersonal relations, procedures unfamiliar to the laymen, a passive role for family members, hospital care, considerable control of the situation by professional healers, and high costs; by contrast the folk medicine of Spanish-American villagers is largely a matter of personal relations, familiar procedures, active family participation, home care, a large degree of control of the situation by the patient and his family, and relatively low costs (Saunders, 1954: 364).*[4]

Seen against this background, it is much easier to understand why so many people regard Western medicine as something of a last resort when all other known procedures have failed (Saunders, 1954: 357).[5][C] Considerations such as these are of primary importance when patients make decisions about the healers they consult at any given time, and they apply equally to choices within Western medicine, as van Selm (1984)[2] demonstrates.

> ***Most patients make use of all kinds of healers in addition to the Western medical tradition.***

Other writers have emphasized the significance of the availability of different types of healers. For example, in a study done in a suburb of Lusaka,[6] Frankenberg and Leeson have shown that Black adult males are twice as likely to consult Western doctors as are females and children — simply because males work in the city where Western doctors are readily available (1976).

Cost of treatment is a particularly problematic issue. No study has yet appeared which has demonstrated that, ***other things being equal,*** patients prefer to pay more for the same medical treatment. Nevertheless, some people have assumed this to be the case[D] and I have even heard it used as an argument in favour of the abolition of all state-assisted medical services.

Much more research needs to be done in this area, but for the moment the observation that some patients consider more expensive treatment to be 'better'[E] should not detract from the more general statement that poverty severely restricts the range of healing options open to many (particularly in some rural areas of South Africa, where cost of transport is a very significant additional factor).

> ***In Crossroads a patient may pay up to R100 to the indigenous African healer, and only 50c to the local clinic!***

WHEN IS CHOICE EXERCISED?

If we acknowledge that the individual patient can and does make use of a variety of healing resources, we need to address the question of ***when*** particular choices are made. With reference to Western/non-western choices, it has already been noted that one system is often chosen when the other has failed. But the 'failure' or 'success' of any medical system is to some extent tied up with its perceived ability to deal with certain types of illnesses.

> *It is in the treatment of acute conditions, severe and sudden infections, surgical emergencies requiring immediate operation to save life, obstetrical complications, the dangerous diseases of infancy and childhood, that Western medicine is so conspicuously superior . . . Wherever Western medicine has reached, people have been quick to recognize its advantages in these fields and to desire for themselves and their families the benefits of such treatment (Maclean, 1971: 24).*[4]

But in the ordinary everyday practice of doctors who serve the general public, whether in third or first world situations, these conditions constitute but a small proportion of the complaints they see. The remaining complaints, those that are deemed to have a 'psychiatric' basis (whether seen as psychosomatic or simply as being aggravated by the patient's anxiety) or those common conditions which invariably run their own course and soon recover, are not necessarily treated

C. Although one must acknowledge that in some cases the opposite holds: people turn to alternative therapy when Western medicine has been seen to fail.

D. "It is a strange philosophy . . . that patients often consider the fees of medical attention to be matched by their quality" (van Selm, 1984: 137).[1] Statements such as these cannot be made unless all other variables are held constant. But even if this could be demonstrated, it is hardly a "strange philosophy" if the whole of the Western cosmetics industry seems to be based on such premises.

E. It is interesting to note that at Crossroads the indigenous African healers were charging up to R100 for their services as compared to the 50c levied by the local clinic.

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more effectively by Western methods. Consequently, patients are more inclined to resort in the first instance to alternative therapies where the less life-threatening illnesses are concerned. In other words, the adage "you can't take every cough to a doctor" still seems to apply.

Healing options outside the domain of the Western medical profession are not confined to 'alternative' professionals such as the exotic 'witchdoctor' and Phillipine healer (who supposedly operates with his hands), or the more familiar homeopath and naturopath. Recent research has directed increasing attention to the importance of non-professional or 'popular' healing resources (see Kleinman, 1980).[9]

It has been estimated that a mere 25% of illness in Britain is dealt with by Western medicine (Elliott-Binns, 1973)[10] and no doubt the percentage is much lower in South Africa.[F] Of the remaining 75%, most illnesses are treated by lay persons or semi-professionals. These included self-treatment, advice obtained from friends, spouses, other relatives (including mothers-in-law!), magazines and medical books, as well as informal consultations with pharmacists and nurses. And, interestingly enough, young patients made more use of such help than the old (Elliott-Binns, 1973).[10]

In the light of such findings it can no longer be argued that these are insignificant aspects of the total health system, or that the treatment of illness outside of the Western health system is on the decline. Nor can we uphold the contention that such activity is restricted to the more 'primitive' societies.

CONCLUSION

This paper has not focussed specifically on the South African situation, primarily because most of the local research has been too narrow in focus and has concentrated largely on so-called 'cultural' motivations. But the findings presented here do serve to emphasize the more universal aspects of the choice of healer. Using these as a broad guideline, individual general

A mere 25% of illness in Britain is dealt with by Western medicine. No doubt the percentage is lower in RSA.

F Given the particularly unfavourable doctor/patient ratio of less than 1:40 000 in some black rural areas (Wells, 1974: 33[7] Wilson, 1980: 450).[8].

practitioners should be able to piece together a much more detailed and specific picture of the range of healing resources which their patients are consulting, as well as of the motivations affecting such choices.

If GPs are aware of the reality of all the healing resoures their patients are using when they are ill, better health care will result.

Perhaps it can be reiterated that neither the different types of healing resources, nor the individual motivations affecting choice, are neatly divisible into mutually exclusive categories. Patients do not consult only one type of healer, nor is there only one primary motivation which influences their decision. The general practitioner constitutes but one link in the whole chain of resources which people utilize when they are ill, and a fuller understanding of this reality can only result in better health care.

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ERRATUM

Diarrhoeal Diseases in the Gelukspan Health Ward — Part II — Paulo Ferrinho.

The following text and table were accidently omitted from page 144 in the May 1985 edition of SA Family Practice:

It can be seen from the Table 3.11 that the experience of diarrhoeal disease plays a significant role in improving the perception of how serious diarrhoeal diseases are. Another important relationship is that in NDD, 32 of 218 respondents (12,5%) knew how to prepare SSS while in HDD, 34 of 116 (22,8%) caretakers knew how to prepare SSS.

So it seems that caretakers who recognize death and dehydration as complications of DD and who have experienced DD in their household, are more likely to learn about SSS.

OPPORTUNITIES FOR EXPANSION

This was assessed by finding the availability of sugar, salt one litre measures and proper sized teaspoons in the households. We tried to assess the size of the teaspoon by comparing them with a standard 5 ml plastic spoon (see Table 3.12).

TABLE 3.12
OPPORTUNITIES TO INTRODUCE AN SSS AT HOME

	No Respondent	Yes	%
Availability of sugar	401	382	95,3%
Availability of salt	401	398	99,3%
Availability of proper-sized spoons	384	329	85,7%
Availability of 1 litre measures	375	250	66,7%

Sugar and salt are almost universally available. Proper-sized spoons are available in the great majority of cases. Only one person said that no teaspoons were available at home, only 5 (1,3%) had spoons bigger than the reference size and 49 (12,8%) had spoons smaller than the standard size.

The limited availability of 1-litre measures (or is it ignorance of what 1 litre is?) is not really a limiting factor as long as we are aware of it when planning and delivering our health education.