

Understanding disease: Are 'first world' and 'third world' patients fundamentally different?

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Kirkby's recent article, 'The dilemma of the first world SA doctor and the third world patient' (*SA Family Practice* 1988; 9: 7), raises the interesting question of patients' explanatory models — the way in which patients attempt to make sense of their illnesses. There is a problem, however, in his use of the 'first world/third world' dichotomy¹ to identify the basic differences between doctors' and patients' explanatory models of disease. This paper argues that 'third world' (or 'Black' or 'African') patients have much in common with patients in the 'first world' ('Whites' or 'Westerners'). The real difference in explanatory models is not between White and Black patients (or whatever other euphemistic terms we choose to describe these racial categories), but between Western medical practitioners and patients.

There is a vast body of anthropological literature which describes, in great detail, the explanatory models (cosmologies, world-views, belief systems) of 'other cultures' or medical systems. In this country perhaps the best known examples of this genre are the excellent works of Harriet

Ngubane² and Vera Bührmann³, which describe the world view (with specific reference to medical beliefs) of the Zulu and Xhosa respectively.

There is a danger, however, that these and other similar works can be used to perpetuate the misconception that the South African population (and hence patients) falls into two neat and mutually exclusive categories — 'Western' and 'African', or 'first world' and 'third world'. The implied assumption of such categorisations is that all 'Africans' or members of 'the third world' have explanatory models of disease which are fundamentally different from all 'Westerners' in 'the first world'. Phrased in another way, Westerners have 'rational' (or 'scientific' or 'natural') beliefs, while Africans have 'irrational' (or 'superstitious' or 'supernatural') beliefs.

Many writers actively contribute to this misconception through gross over-generalisation. For example, David Hammond-Tooke, a prominent South African anthropologist, writes:

The first thing to grasp is the fundamental difference in ideas of causation between Western man and the African. Among all Bantu-speakers all misfortune, and all illness and death, except that from extreme old age, is sent by supernatural beings. There are

*two possibilities and only two. The misfortune can be caused by ancestral shades or by a witch/sorcerer.*⁴

Similarly, Vera Bührmann comments that the African world is 'primarily intuitive, non-rational or oriented toward the inner world of symbols and images', while the Western world is typified as 'scientific, rational and ego-oriented'.⁵

Statements such as these appear to deny that Africans (members of the 'third world') have the capacity to think rationally or to understand natural causes of disease, and ignore the reality of change associated with a long history of contact with Western medicine.

'Rationality' in the 'third world'

Modern anthropologists recognise that their predecessors were over-zealous in their attempts to describe the exotic beliefs and practices of people in 'other cultures'. Because they were primarily interested in differences, early anthropologists tended to overlook beliefs about disease causation which were the same as those assumed to be prevalent in their own societies. Nonetheless, several early ethnographies do document the existence of ideas about the natural causation of disease. Although beliefs about ancestors

and witchcraft attracted most attention, several authors note that most common illnesses (such as colds, mild infections, physical injuries) were seen to have been caused naturally⁶. Similarly, a recent study of health beliefs in rural Lesotho indicates that witchcraft and ancestors are only invoked in a minute proportion of illness episodes, and that people have a good understanding of the natural causes of the most common disease conditions (such as diarrhoea and diseases associated with malnutrition)⁷.

One also needs to make the point that 'natural' and 'supernatural' explanations of disease are by no means incompatible. Not only do we often find that the same

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person employs 'natural' and 'supernatural' explanations for different illnesses, but also for the *same* illness episode. Prof Monica Wilson, a previous head of social anthropology at UCT used to relate the story of an African friend of hers, a trained nursing sister, whose mother had become ill. During a conversation it emerged that the nurse was invoking an explanation in terms of witchcraft to account for her mother's illness. Prof Wilson found it surprising that someone with a scientific training should still believe in witches. 'I know that the illness is a viral infection', came the response, 'but I also need to know who sent the virus'.

Finally, one should be cautious about the use of 'irrational', 'illogical' or other related terms.

Very often 'supernatural mumbo-jumbo' makes perfectly good sense, not only to those who hold such beliefs, but even to outsiders. Consider the following example:

An African mother takes her child, who is suffering from a disease commonly associated with malnutrition, to a local clinic. The doctor diagnoses the disease and prescribes appropriate medication. Two days later the child is much improved, but after a few weeks the symptoms return. As a result, the mother decides that the Western medical treatment was not effective, and seeks help from an indigenous African healer.

This healer, who knows the family background of the patient quite well, divines the cause of the illness to the wrath of the ancestors. The ancestors, who watch over the living, are displeased with the father's behaviour — he has been drinking excessively and consequently lost his job a few months previously. He is therefore neglecting his responsibilities as father and bread-winner, and the ancestors are punishing him by causing his child to become ill. The cure involves 'mending his ways'.

Few of us would deny the underlying rationality of the 'witchdoctor's diagnosis, even though it was phrased in terms of the ancestors. Furthermore, which course of treatment was likely to be more effective in the long term?

'Unscientific' models in the 'first world'

Some recent anthropological research has concentrated on lay perceptions of health and disease in Western countries.⁸ The results have consistently shown that popular explanatory models

of disease differ significantly from those of Western Medicine. Nor is there any evidence to suggest that this pattern is changing as people become more educated. In fact, the so-called 'alternative' healers seem to be gaining in popularity, *especially* among the better educated and wealthier classes.

Lay explanatory models in Western countries often *appear* to be 'scientific' because they incorporate terms commonly used in Western medicine. 'Viruses' and 'bacteria' are common examples of terms widely used by lay persons. Research conducted by students in the anthropology department at UCT shows (not surprisingly) that 'viruses' and 'bacteria' are

*“Viruses” and
“bacteria” used
interchangeably*

commonly used quite interchangeably (hence the belief that antibiotics cure viruses). They were described as 'germs', 'bugs' or 'goggas' which 'travel through the air and enter the body to make you sick', and were depicted in drawings as resembling amoebas, tadpoles or spiders. In short, for many (most?) 'first world' patients 'viruses' resemble the widespread African idea of 'snakes in the belly' more closely than the scientific notions of these terms.

Sometimes popular beliefs form part of a coherent explanatory model about disease causation and cure. For example, I recently discussed the issue of high blood pressure with someone who seemed to have a much better understanding of automobile engines than of the human body:

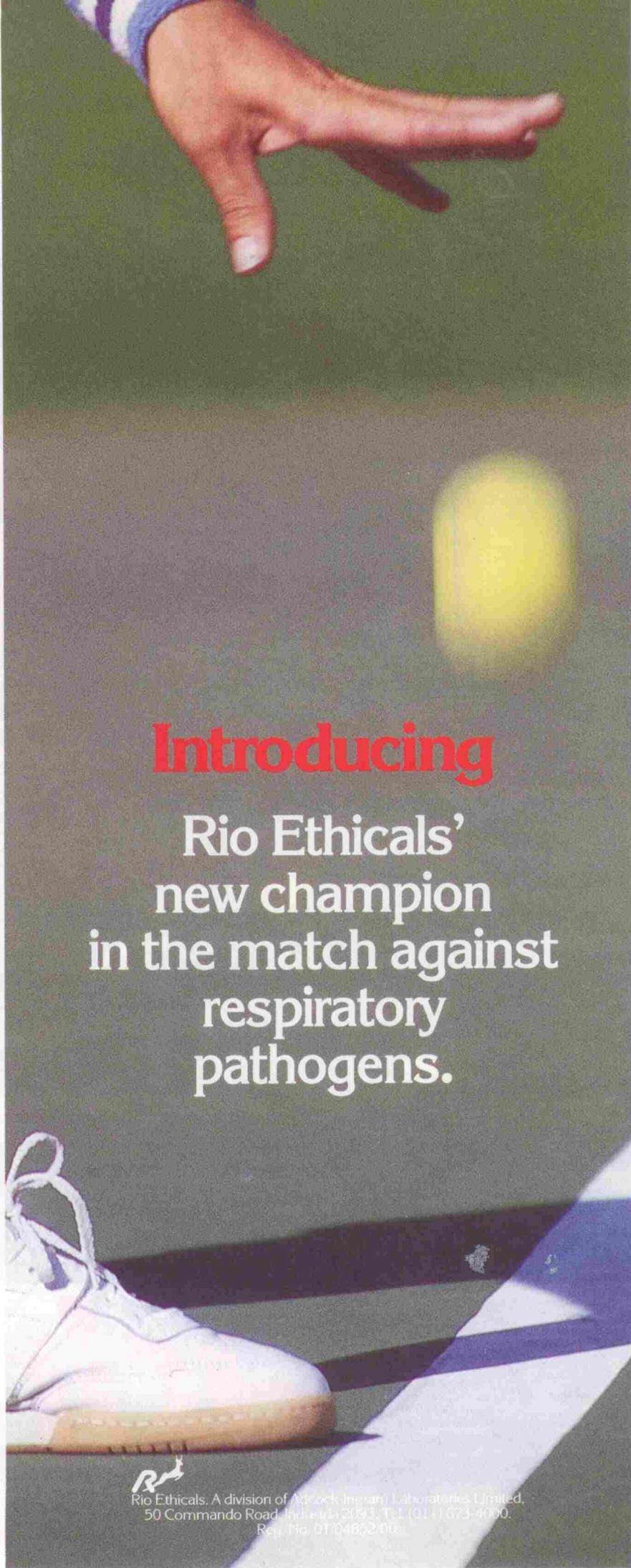
Like oil, blood can get too thick and then it has difficulty traveling through the veins — causing high blood pressure. And like grease, it can be thinned or diluted by acids (like the 'grease-cutting' power of lemon in certain dishwashing products). So people with 'high blood' should drink plenty of lemon juice and vinegar and eat ample pickles.

A variant of this model relates to the view that blood becomes 'dirty' and needs to be 'cleaned' or 'purified' — witness, for example, the common request for medication to 'clean the blood'.

Conclusion:

There are countless other explanatory models of disease which are at variance with Western medicine, and they are by no means peculiar to 'third world' populations. Most of us would acknowledge that these explanatory models are highly variable and even individualistic among 'first world' patients. Some 'first world' patients are more 'superstitious' than others, and one cannot predict (on the basis of sex, age, education, or any other criterion) what an individual patient's explanatory model of a particular disease will entail. And yet we tend to do this with 'third world' patients. We often assume that they all think in the same 'superstitious' way, and that they are all ignorant of 'scientific' insight. At best, we believe that they can be classified into different 'cultures' or 'tribes', each with its own 'world view'.

In the same way that we cannot assume that all White patients are atheistic scientists, we cannot assume that all Black patients believe in ancestors or witches (or invoke such explanations for all diseases). It is important that general practitioners should



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learn about different explanatory models — not in order to stereotype and type-cast patients, but so as to increase their sensitivity towards the possibility of explanatory models which are at variance with their own. This applies to all patients, not just to those of the 'third world'.

Notes:

1. For a fuller discussion of the problems inherent in this terminology, see Sharp J S. Two worlds in one country: 'first world' and 'third world' in South Africa. In Boonzaier E, and Sharp J (eds.)

South African Keywords, Cape Town: David Philip, 1988.

2. Ngubane H. *Mind and body in Zulu medicine*. London: Academic Press, 1977.
3. Bührmann M V. *Living in two worlds: communication between a white healer and her black counterparts*. Cape Town and Pretoria: Human and Rousseau, 1984.
4. African worldview and its relevance for psychiatry. *Psychologica Africana*. 1975; 16: 25-32.
5. Bührmann M V. *Living in two worlds: communication between a white healer and her black counterparts*, Cape Town and

Pretoria: Human and Rousseau, 1984: 15.

6. See, for example, Hunter M. *Reaction to conquest: effects of contact with Europeans on the Pondo of South Africa*, London: Oxford University Press, 1936; and Evans-Pritchard, E E. *Witchcraft, oracles and magic among the Azande*, Oxford: Clarendon Press, 1937.
7. Heap M. *Health and disease in two villages in south-eastern Lesotho: a social anthropological perspective*, Unpublished M A thesis, UCT.
8. See, for example, Helman C. *Culture, health and illness*. Bristol: John Wright and Sons, 1984.

Suggested early management of suspected acute AMI

These cards are available, free of charge, on request from: SA Family Practice/ Primary Care, Medical House, Central Square, Pinelands 7405. They are useful to keep on your desk or in your briefcase.

SUGGESTED EARLY MANAGEMENT OF SUSPECTED ACUTE MYOCARDIAL INFARCTION (AMI)*

- (a) **GENERAL:**
 - (1) Respond to any suspicious case *immediately*;
 - (2) Treat any suspicious cases as an AMI;
 - (3) Reassurance;
 - (4) All drugs to be given *intravenously*, slowly and diluted unless otherwise stated;
 - (5) Patient positioned *flat* unless otherwise indicated.
- (b) **PAIN:**
Morphine — "Average" dose 7,5 mg, given in increments of 2 mgs.
- (c) **SEDATION:**
Diazepam in multiples of 2 mgs *orally*.
- (d) **NAUSEA:**
Atropine, an anti-emetic is given routinely in situation (e) otherwise use metaclopramide 10 mgs.
- (e) **PROPHYLAXIS AND TREATMENT OF MINOR DYSRHYTHMIAS (ROUTINE):**

(1) Pulse rate under 60 beats per minute — with or without ectopic beats.	Atropine in doses of 0,6 mgs till a reasonable rate (70-90) achieved.
(2) Pulse rate 60 — 110 beats per minute — N.B. no dilution necessary.	Lignocaine 100 mg (i/v) (5 ml of 2%) 200 mg (i/m) (5 ml of 2% in each buttock).
(3) Ectopics present — after atropine induces tachycardia.	Lignocaine in above dosages.

(Lesser dosages of Lignocaine in hepatic insufficiency, pump failure and elderly. Mexiletine is an acceptable alternative to lignocaine.)
- (f) **MAJOR ARRHYTHMIAS:**
(Difficult to diagnose without ECG, but are not common in early phase of AMI.)
 - (1) Supraventricular — often associated with CCF — Digoxin,

others, e.g. Verapamil, Disopyramide.
(2) Ventricular — Lignocaine, Disopyramide, Mexiletine.
If any doubt as to cause of rapid regular tachycardia, the administration of Lignocaine is fully justified.

- (g) **CARDIAC ARREST:**
 - (1) Patient on hard surface (e.g. floor);
 - (2) Head back to clear airway;
 - (3) Thumps on chest;
 - (4) Cardiac massage 15 pushes to 2 mouth-to-mouth respirations;
 - (5) Urgent help.
 - (h) **CCF OR PULMONARY OEDEMA:**
Routine anti-failure therapy; Digoxin†, Aminophylline, Frusemide, oxygen (if available). Patient nursed in sitting up position.
 - (i) **"SHOCK":**
(Low blood pressure does not equal true cardiogenic shock and often responds to treatments (a) — (ii)).
 - (1) Lie patient flat and raise legs;
 - (2) Atropine (as indicated in (e) if pulse slow);
 - (3) Digoxin†;
 - (4) Oxygen if available;
 - (5) Remember to try find cause for hypotension e.g. arrhythmias;
 - (6) Beware of giving powerful inotropic drugs, e.g. Isoprenaline, in unmonitored situations.
- †Digoxin should be only given if absolutely necessary.

This card is issued as a guide and not as a substitute for the literature.

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***REFERENCES:**

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- (2) Levenstein J.H. (1976): S.A. Med. J. 50, 531.
- (3) Levenstein J.H. (1982): Update, March, 846.
- (4) Levenstein J.H. (1982): Update, April, 1305.
- (5) Levenstein J.H. (1982): Update, May, 1785.
- (6) Bell J.A., et al. (1982): Brit. Heart. J., 48, 285.

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