

Western and Traditional medicine

From the Regions Natal Coastal Branch

Garth Brink sent the following talks given at a very successful meeting held on 22 April 1987 by the Academy in Durban. The theme was Western and Traditional Medicine. One hundred and thirty people listened to Drs Gumede and Hackland and Mr Cele, a registered inyanga. A lively discussion followed the talks. Perhaps by placing the two talks together it will stimulate some correspondence?

Introduction by Dr Russell Kirkby

The practice of Medicine begins when a person who is ill, or perceives himself to be ill, confides in a doctor in whom he places his trust. This is a consultation and all else in medicine flows from this.

Without communication there can be no successful consultation. Robert Adrey has said that "We may praise communication but in the human species non-communication might seem to be a more striking feature of our way." Communication may be defined as a process whereby a transmitter transmits to a receiver the same understanding of the situation as he has.

In South Africa everything is divided into colours and races. Some figures from the recent MASA Congress make interesting reading. Whites who make up 18% of the population provide 84% of the doctors in the country. Asians make up 3% of the population and provide 10% of the doctors. So-called Coloureds make up 10% of the population and provide 3% of doctors. Blacks make up 68% of the population and provide 2,2% of the doctors.

Considering these figures in this complex country of ours with its mixture of First and Third World standards, multiplicity of ethnic groups, languages, cultures, traditions and beliefs, very few of us will work exclusively in communities whose language and cultures are the same as ours.

All of the above, and many other factors are great barriers to effective communication and hence to effective consultation and management skills.

This meeting is an attempt to gain more understanding of the beliefs and traditions of a large proportion of our patients. More especially, we hope that this will jog our complacency and make us more aware of the needs of that most forgotten part of the medical process - the patient.

The speakers that we have tonight are all extremely experienced men and experts in their fields. We look forward to their talks with interest and would like to thank Lennon Laboratories for making this evening possible.

We have three speakers and I would like to introduce two of them.

Dr Mordecai Gumede

Dr Gumede is both a qualified teacher and medical doctor and has worked in numerous mission hospitals in Natal, KwaZulu and Pondoland as a Medical Officer and Superintendent. He has worked as a General Practitioner and District surgeon, has been in charge of the Kwasimama Clinic for Health and Welfare of KwaZulu from 1979-1983. He has served on numerous hospital boards, university councils, school and church boards. He lists amongst his hobbies, that of Zulu history and the study of Traditional Medicine and Traditional Healers. He is actively involved in the Bureau of Zulu languages and culture.

He is eminently suitable to address us on this topic.

Dr Darryl Hackland is another teacher-cum-doctor and is at present secretary for Health and Welfare in KwaZulu Department of Health and Welfare. In between qualifying as a teacher and doctor he worked in the Methodist Church Ministry. If one considers holistic care, these are indeed qualifications for providing succour in body and spirit. Having had the privilege of working under Darryl when he was Superintendent at Bethesda Hospital in Ubombo, and when he was a paediatric registrar at Addington, I can vouch for the fact that his official qualifications don't stay attached to his study wall, but extend very effectively into his practical day-to-day practice. He also serves on numerous boards, committees and councils, and we are grateful he could find the time to address us.

HEALERS MODERN AND TRADITIONAL

Dr MV Gumede Medical Officer, Kwamashu Polyclinic

For 335 years, life in South Africa has been characterised by separateness. This has received different names at different times, eg Baas-skap, colour bar, segregation, white trusteeship, apartheid, consociation, etc. As a result we have missed observing crucial changes. My father was a kaffir; I was a native; my children were Bantu; my first granddaughter was a pleural; my second granddaughter was nearly an African, but some said call them Black, lest they think they are also Afrikaners. We all know my first grandson is a South African as we now all have a common citizenship.

Ladies and gentlemen, this is an epoch-making occasion - when modern doctors and traditional healers get together to share views on the art of

healing. In the final analysis we all have the same objective, namely, healing our patients:

*to cure - sometimes
to relieve - often*

but, *to comfort - always*

For arranging this meeting the chairman deserves a loud pat on the back.

My function is merely to kick off. I will kick off by sketching the differences between

Traditional Healers vs Modern Healers (see table on right).

African society has shifted from the old extended family of old when 3 or 4 generations were found living together in one kraal to the nuclear family of father, mother and child. The old 3rd and 4th generations resisted and applied brakes to halt the rapid change. The nuclear family is prone to rapid

Traditional healers	vs	Modern healers
1. Indigenous, African - Izinyanga		1. Western, imported, medical practitioners
2. In existence 4500 BC Kush/Ethiopia		2. Fathered by Hippocrates
3. Irrational		3. Rational
4. Empirical		4. Scientific
5. Surgical procedures: crude, primitive, unscientific		5. Surgical procedures: scientific planned based on gross and morbid anatomy.
6. Training is from father to son or from master healer to trainee (Udibi) apprentice, journeyman. Training takes a life time.		6. Training is available to anyone who has the necessary requirements. Training takes a minimum of 7 years.
7. Disease is believed to be unnatural - man-made through the agency of spirits.		7. The germ theory postulates disease follows a breach of the laws of nature.
8. Diagnosis means WHO caused the illness		8. Diagnosis means WHAT caused the illness.
9. Wholistic treatment.		9. Treatment is Individualistic.
10. There are some 120 000 Inyangas excluding TBAs, sangomas, etc.		10. —
11. Inyanga treats patient within his environment - physical, spiritual, emotional - his past		11. The modern doctor treats the disease - destroys the offending organism, patient will be well.
12. Rules of ethics were high; not enforced by a high code of conduct		12. Code of conduct laid down and enforced by the Medical Council.
13. Stress is laid on — (a) The troubled, viz. patient (b) The soil, viz. environment physical and cosmic		13. Stress is laid on — (a) The trouble, viz. disease (b) The seed, viz. germ and the disease
14. The IDIOM of approach is thus social, political, economic, moral, religious and even recreational.		14. The LANGUAGE of modern medicine is aetiology, symptomatology, diagnosis, epidemiology, endemiology, preventive, curative, prognosis, rehabilitation.



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changes. The Zulu, like any other black South Africans, has been subject to wide diffusion of culture and has adopted many ways of the newcomers from the East and the West. Thus rural and urban Zulus only exist in the statute books.

The practice of medicine begins when a person who perceives himself to be ill, confides in a doctor in whom he trusts, all else in medicine flows from this

There is an excellent transport service. A Zulu has breakfast at Mahlabatine, boards a Combi in the morning to shop at the Hypermarket by the Sea, takes another Combi back home to have supper at Mahlabatini. There is thus little difference between urban and rural.

Youth is, at all times, prone to rapid change. Be it remembered:

- 45% of Black SA is 15 years and under
- 66% of Black SA is 25 years and under
- 15% of the population of the Republic of Germany is 15 years and under.

Result is a confused process of acceleration which sets the scene for rapid change - no urban, no rural Zulu.

The Zulu is a polygamist who lives in an exogamous patrilineal society. Inheritance is determined by the laws of primogeniture. The Zulu needs plenty of daughters to recoup his 11 cattle he paid as lobola for his wife. His wives must give him an heir to perpetuate the name of his family. All these factors lay strong demands on the Zulu's procreation machinery. A large brood enhances his prestige in this and the next world. He must have strong medicine to give him sexual prowess and maintain fertility. The Inyanga has a wide range of aphrodisiacs.

The Zulu has always lived with a high perinatal mortality - all authorities confirm that the African perinatal mortality is three times that for whites.

Year	Place	Mortality per 1000	Authority
1982	KwaZulu	22-93 per 1000	Pat Garde
1983	KEH	83 per 1000	Prof Philpott
1983	Dududu/ZG	147 per 1000	J V Larsen
1983	Valley of 1000 Hills	113 per 1000	Friedman
1984	N/Natal	119 per 1000	Darryl Hackland
1986	KEH	55 per 1000	Sam Ross

cf. Perinatal mortality for whites in 1982 showed 14-21 per 1000.

Thus the African needs strong medicine to replenish supplies in his reproduction factory. He is in all things full of verve and virility. Watch him at his Zulu Ngoma Dance!

What do African patients expect from Western doctors

Patients are the same the whole world over. All are ill at ease. They seek and welcome help from any source. They go to a healer, modern or traditional, expecting to be helped to get rid of their illness - real or imaginary. The process is the same everywhere. Patients expect their doctor to listen to their woes, examine them, arrive at some diagnosis, tell them the diagnosis, viz to answer the simple question:

"Doctor what do I suffer from?"

Thereafter outline the course of treatment, medical, surgical or referral to specialist or hospital *and why this is necessary for the patient's well-being.*

This is what all of us, you and I, expect of him when we go to the doctor as patients or when we send our loved ones to him. So do Zulu patients.

What they do not expect is:

- (a) To be made to sit on old tomato boxes while they wait for doctor.
- (b) To be pushed through a sausage-like machine process of consultation with emphasis on the number of patients seen - with, in turn, the number of consultation fees.
- (c) To see an impatient doctor in a foul mood when he sees them but all sweet reasonableness when he sees patients other than them.
- (d) To be told they suffer from native diseases and all the sangoma mumbo-jumbo that goes with it.
- (e) To be examined with a stethoscope fully dressed auscultating the forehead, the knee and the toe.

Nor do they expect this from a traditional healer either.

To put the record straight: What they expect is just a consultation in a relaxed atmosphere, a good bedside manner which inspires confidence, reassurance of cure, or just support if and when cure is not possible.

Black South Africans have adopted many ways of newcomers from East and West, thus rural and urban Blacks only exist in the statute books

This is the traditional healer's trump card. He may even work in his patients' homes at night and sleep there. Imagine the confidence inspired in both patient and relatives by the presence of this very gifted son of the gods. When the traditional healer wins the confidence of his patient half the battle is won as both patient and relatives have been placed in a frame of mind psychologically receptive to treatment and conducive to recovery.

If it be accepted in the medical community as in the financial community that the customer is always right, our patients do not agree with us that the traditional healer has no role to play in our health care delivery services. We need to review our attitude towards the traditional healer as a health resource.

Some interesting food for thought

1. Over 50% of babies born in the Black community are born outside the hospital and the clinic. TBAs and traditional healers are providing this invaluable service at no cost to Government.
2. 80% of all black patients visit the traditional healer before they visit the doctor, the clinic or the hospital.
3. Of the 20% of unbooked maternity patients at King Edward VIII Hospital, 60% had been attending a traditional healer, in Sam Ross' series.
4. The cost of being alive is rising and will soon be a luxury. Even medical aid schemes are so expensive, 70% only of white workers benefit from medical aid; 36% to 26% of Indian and Coloured workers; 4% only of the black work force can pay medical aid.

5. Modern medicine is now HIGH TECH. Technology is expensive and not easy to come by

It takes 4 years to train a Health Inspector
4 years to train a Medical Technologist
4 years to train a Pharmacist
6 years to train a Dentist
6 years to train today's professional nurse, ie RN, RM, CHN, DPN
7 years to train a Medical Practitioner

The traditional healer is a ready-made easily available health resource within the community at risk - and at no expense to Government. The Community Health nurses at Phungashe Clinic are already engaged in dialogue with the traditional healers on management of TB.

In conclusion, illnesses can be divided into 3 groups.

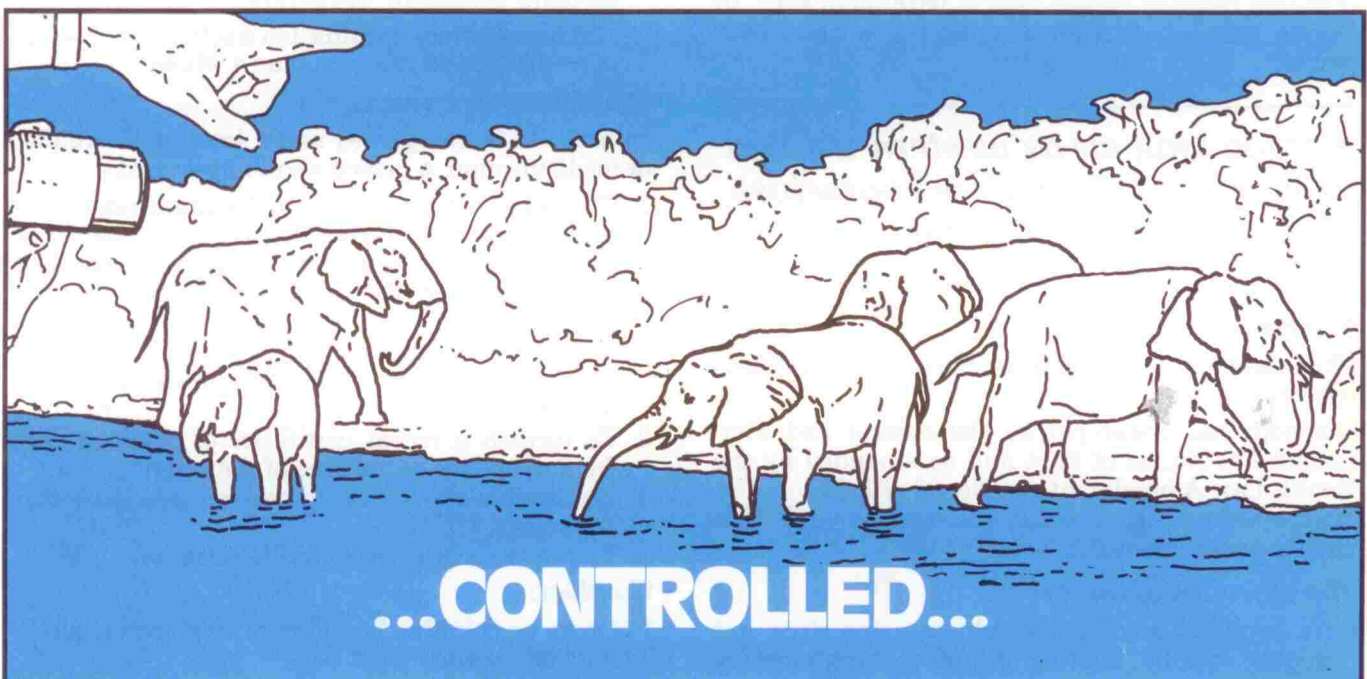
1. Those which are entirely mental
2. Those which are physical but tend to limit themselves, and
3. Those which are physical but do not tend to burn themselves out.

80% of all illnesses belong to the first 2 groups.

The function of the healer (modern or traditional) is to pick out from his patients the 10% to 20% who would die without appropriate treatment.

Therefore, both the modern and the traditional healer have an equal chance of success, because all of us are given the power and the right to treat our patients.

But only He the giver of all things does the healing.



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THE TRADITIONAL HEALER IN MODERN SOCIETY

Dr D Hackland
Secretary for Health, KwaZulu

We have been looking forward to this meeting with great anticipation and expectation for some months now. I am very glad that Mr Cele, a number of his colleagues and Dr Gumede are here this evening. I consider them the experts in the field and therefore my contribution will be but small.

I believe that it is to your branch's credit that such a meeting has been arranged. Here is the opportunity to sit down and find one another as forces for healing in the community. The attitude that "I haven't all the answers" in the art of practising in the field of healing is most encouraging. Perhaps for too long we, as the western type, medically trained model, have considered ourselves to be the only model, holding the monopoly over all who would seek a real cure for their human suffering.

Having practised for 12 years in rural KwaZulu, it was only some years after commencing that I had the fortune to really bridge the gap that existed between the traditional healer and myself. Perhaps there was an attitude, brought out by some experiences, eg patient expressing desire to go home to consult his own "doctor"; but nevertheless, an understanding of the value of the so-called traditional healer only came when for me the turning point was reached - I was invited to consult together with a traditional healer on his ground, in his "hospital".

I have headed the short input - The Traditional Healer in Modern Society. I for one, do not doubt that this cadre of health care is with us to stay. In saying this I draw your attention to a number of points.

For too long we as western trained doctors have considered ourselves to be the only model

Firstly

The existence of an act in the Statute Books of this country.

Homeopaths, Naturopaths, Osteopaths and Herbalists Act No. 52 of 1974 and as amended by the Health Law Amendment Act No. 36 of 1977.
Homeopaths, Naturopaths, Osteopaths and Herbalists Amendment Act No. 90 of 1980.

The objective of the Act

- To prohibit any person whose name does not appear on a list kept by an officer designated by

the Minister of Health, from practising for gain as a homeopath, naturopath, osteopath or herbalist.

- To exempt Black medicine men and herbalists from that prohibition and certain other laws.
- To provide for incidental matters.

Secondly, The Association

In pursuance of the Act in the Province of Natal and KwaZulu the Inyangas' National Association has been in operation for some years. Its present President, Mr SB Janile, was elected in October 1985. He is, in addition to his own practice, a member of the KwaZulu Legislative Assembly. I am sure there is a strong bond between the present President and Ellen Hilda Janile (1874-1962/88 years) known as Empethamaqile who is quoted as saying "There are no such things as incurable diseases: there are only diseases for which man has not found a cure."

The Association has a Constitution, this being approved by the KwaZulu Government on the 5th December 1983.

Aims and Objectives of the Association (amongst others):

1. To consider and promote reform and improvements in the practice of medicine men.
2. To represent generally the views of the profession; to preserve and maintain its integrity and status, to advance and enforce correct and uniform practice and discipline among its members; to suppress dishonourable conduct or practices such as witchcraft.
3. To encourage and promote the study of medicine; to provide means for securing efficiency and responsibility on the part of those seeking admission to the profession; to conduct or regulate inyangas' examinations and to collect and disseminate information likely to be of value to members and the nation as a whole.

Qualification criteria

In order to be recognised as an Inyanga, herbalist or medicine man, a person shall be required -

1. To undergo training as an Inyanga under the supervision of a licensed Inyanga for a period of not less than 10 years, at the commencement of which training the said person shall not be under 18 years.
2. To satisfy a panel of at least 3 senior licensed Inyangas as to his competency and efficiency as an Inyanga.
3. To furnish a recent certificate of good conduct from the police at the time of the examination.
4. To obtain a Government licence to practice as an Inyanga.
5. To become a member of the Association.

Conduct:

1. Gross or culpable blunders or negligence entailing bad results.

2. Assumption of European title of Doctor or Chemist.
3. Advertising.

Through the Association the recommendation is made that a candidate's name be entered on such a register kept by the Department of Health by virtue of training he receives or had received.

Thirdly

The Registered Practitioners (practising estimated 120 000 countrywide). Licensed by the Minister of Health.

At present: 167 licensed Inyangas in Kwa-Zulu: 111 Male 56 Female

Applications: 40/year

Successful: 15/year

Fourthly

Actual consultations are being made and certificates of indisposition are received.

What about the legal standing? Do we accept it or don't we?

Fifthly

Formation of the SA Traditional Healers Council. State President meeting with Councillors 18.2.87.

Here is a vast business undertaking, simulating a Traditional Healers "Medical" Association of Southern Africa which will be to gain recognition of the Government of the RSA - Gumede 29.10.86.

I believe their initiative must be watched with great caution for the possibility is here that those who presently practice without permits, some using stethoscopes, some giving injections, are admitted as members of this international Traditional

Healers' Organisation and it becomes clear that quacks, charlatans and cheats will have a field day in medical practices with legal backing.

There have been other attempts to bridge the gap of understanding. In 1947 the Dingaka's Association asked the Medical Council for recognition and registration and authority to function alongside the rest of the healing profession - doctors, nurses, etc.

Reply of Medical Council was simple: Tell me:

How do you examine your patients?

How do you arrive at a diagnosis?

What drugs do you use to treat your patients?

How do you arrive at correct dosages?

The Inyangas promptly replied: We are not saying anything.

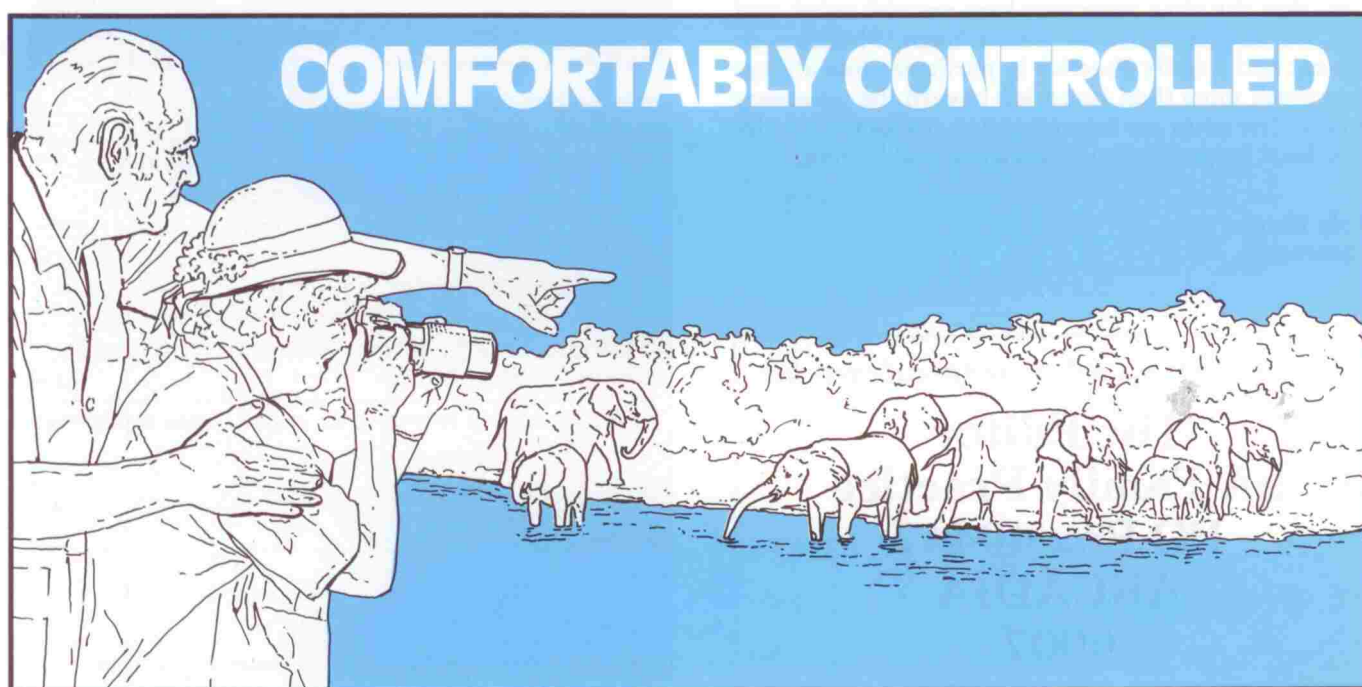
They retreated behind the herbs and gallbladder curtain. Stalemate.

There is no doubt that in caring for the health of the community, the Traditional Healer has a place in the provision of primary care. We remain with valid points:

1. The Traditional Healer is as old as Africa.
2. The Traditional Healer is an adept practitioner at diseases that are a result of mind over matter.
3. That by and large the bulk of the community still values the services of the traditional healers.

We recognise them but we need to move closer in understanding.

1. We need to know more - this conference will be such an experience.
2. Use of video on Life Story of An African Inyanga, Uqqoko Productions, PO Box 287, Amanzimtoti. *S Afr Med J* 6 Dec 1986; Vol 70: no 12, page XIV.
3. Learn the language - ZULU.



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